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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2018	2018_630589_0011	007753-17, 008984-17, 022298-17, 026610-17, 027593-17, 027880-17, 002200-18, 003340-18, 003749-18, 008962-18, 015921-18, 021047-18, 021914-18, 023011-18, 025086-18, 025643-18, 026189-18, 026453-18, 027248-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Midland Gardens Care Community
130 Midland Avenue SCARBOROUGH ON M1N 4E6

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

JOANNE ZAHUR (589), ARIEL JONES (566), NITAL SHETH (500), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 30, 31, September 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, October 23, 24, 25, 26, 29, 30, 31, November 1, 2, 5, 6, 7, 8, 9, 14, 15, 16, 19, 20, 21, 22, 26, 27 & 28, 2018, and December 4, 2018 (off-site).

The following complaints were inspected during this inspection:
-log #007753-17 related to Prevention of Abuse and Plan of Care,
-log #008984-17 related to Prevention of Abuse and Police notification,
-log #022298-17 related to Laundry Service, Resident's Bill of Rights, Plan of Care and Duty to Protect,
-log #26610-17 related to Plan of Care, Falls Prevention, Critical Incident reporting and Responsive Behaviours,
-log #027593-17 and log #027880-17 related to Falls Prevention,
-log #002200-18 related to reporting Certain Matters to Director and Transferring and Positioning technique,
-log #003340-18 related to Prevention of Abuse, Plan of Care
-log #008962-18 related to Plan of Care, Prevention of Abuse and Reporting Certain Matters to the Director,
-log #015921-18 related to Infection Prevention and Control Program, Cooling Requirements, Maintenance Services, Continence Care and Bowel Management and Dining and Snack Service,
-log #021047-18 related to Prevention of Abuse, Resident's Bill of Rights, Pain management and Skin and Wound Care,
-log #021914-18 and log #023011-18 related to Plan of Care, Falls Prevention, Prevention of Abuse and Elevators,
-log #025086-18 related to Plan of Care and Skin and Wound care,
-log #025643-18 related to Prevention of Abuse, Plan of Care, Continence Care and Bowel management, Housekeeping and Skin and Wound Care,
-logs # 026189-18 and log #026453-18 related to Prevention of Abuse and Maintenance care, and
-follow-up log #027248-18 related to Prevention of Abuse.

Written Notifications and Compliance Orders related to LTCHA, 2007, S.O. 2007, C.8, s. 19. (1), identified in concurrent inspection #2018_626501_0021, (log #016362-17/CIS #2789-000062-17 and log #011925-18/CIS #2789-000045-18) will be issued in

this report.

Written Notifications and Compliance Orders related to LTCHA, 2007, S.O. 2007, C.8, s. 24. (1), identified in concurrent inspection #2018_626501_0021, (log #011925-18/CIS #2789-000045-18) will be issued in this report.

Written Notifications and Compliance Orders related to LTCHA, 2007, S.O. 2007, C.8, s. 6. (7), identified in concurrent inspection #2018_626501_0021 (log #024015-18/CIS#2789-000075-18) will be issued in this report.

Inspector Babitha Shanmuganandapala #673 was on-site for this inspection on September 19, 20, 21, 25 and 26, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Administrative Director of Care (A-DOC), Clinical Director of Care (C-DOC), Nurse Managers (NM), Director of Resident Programs (DRP), Registered staff (RN/RPN), Resident Relations Coordinator (RRC), Registered Dietitian (RD), Occupational Therapist (OT), Physiotherapists (PT), Acting Director of Environmental Services (A-DES), Behavioural Support Nurse (BSN), Office Manager (OM), Payroll Co-ordinator (PC), Physician, Personal Support Workers (PSW), Housekeeping Aides (HA), Maintenance Worker (MW), Resident Program Team (RPT), Dietary Aide (DA), Scheduling Clerk (SC), Minimum Data Set-Resident Assessment Instrument Coordinator (MDS-RAI-C), receptionist, substitute decision makers (SDM), family members, and residents.

During the course of the inspection, the inspector(s) observed meal services, staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, maintenance records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **7 VPC(s)**
- **4 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	Légende 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.

The following evidence related to resident #009 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC and according to this report, resident #009 had communicated on a social media platform with visitor/volunteer #208 who had been inappropriate towards them. The visitor first reported the conversation to staff #133, though only a small portion. Resident #009 later provided the entire conversation thread to staff #133 in which it indicated that visitor/volunteer #208 had been entirely inappropriate with them.

An interview between an inspector and staff #183 indicated that visitor/volunteer #208 had only been a volunteer for five months in 2017. According to staff #183, visitor/volunteer #208 did not work out as a volunteer for various reasons, including inappropriate interactions with residents. Visitor/volunteer #208 continued to visit the home as they were part of the Family Council and also had become a substitute decision-maker (SDM) for an identified resident residing in the LTCH.

An interview between an inspector and resident #009, indicated that during a social media platform interaction with visitor/volunteer #208 regarding resident #009's missing clothing, the messages became inappropriate. Resident #009 thought that resident #027 was wearing their missing clothing and had asked they be given back.

A review of the social media platform interaction provided by the LTCH indicated that visitor/volunteer #208 had used inappropriate language in their messages to resident #009 and spoke of resident #009's underlying health status. According to resident #009, after receiving the above mentioned message they went and informed the management of the LTCH.

A review of the CIS report indicated the police had advised resident #009 to stop all communication with visitor/volunteer #208 and if this person should try to contact the resident again, to inform the management of the home who will follow up with them. When speaking with an inspector, resident #009 stated the interaction had made them upset. Resident #009 further stated visitor/volunteer #208 uttered an inappropriate comment about them after seeing them coming out of staff #133's office.

There was previous evidence that resident #009 and visitor/volunteer #208 had an

encounter that was described as inappropriate in an email communication from staff #133. Review of this email communication provided by staff #183 to the inspector indicated that staff #133 had received a complaint from resident #009 that visitor/volunteer #208 had spoken inappropriately at them in the courtyard regarding designated smoking areas. Resident #009 further stated that visitor/volunteer #208 had gotten close to them during the above mentioned interaction.

In an interview, staff #133 stated that after the courtyard incident, the LTCH had sent visitor/volunteer #208 written communication regarding their inappropriate interactions with resident #009. Staff #133 acknowledged that visitor/volunteer #208's interactions with resident #009 had been inappropriate. [s. 19.]

2. The following evidence related to resident #025 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC and according to this report, staff #100 had reported there was a commotion in front of the dining room and had observed staff #178 and resident #025 were in the vicinity with no other PSWs around. Staff #100 went to investigate what had happened and noticed resident #025 had an area of altered skin integrity. The police were informed of the incident.

A review of resident #025's medical record indicated the resident had been admitted to the LTCH with underlying health conditions and an impaired cognitive status. A review of an assessment indicated resident #025 exhibited responsive behaviours. Resident #025's plan of care indicated to staff interventions and strategies to be implemented when they were exhibiting responsive behaviours.

A review of resident #025's progress notes indicated that staff #100 had documented they had observed resident #025 exhibiting a responsive behaviours towards the staff. Staff #100 also observed that resident' #025's had an areas of altered skin integrity that they were unable to assess at that time due responsive behaviours being exhibited by the resident.

In an interview, staff #100 verified the above noted progress note entry and stated they thought the incident was abuse and therefore reported it immediately to their manager.

A review of the home's investigation notes indicated staff #178 had admitted they had inappropriately touched resident #025 resulting in an area of altered skin integrity.

In an interview, staff #105 acknowledged the home had failed to protect resident #025 from abuse from staff #178. [s. 19.]

3. A CIS report was submitted to the MOHLTC regarding resident #023. The report further indicated that resident #023 had an area of altered skin integrity that was wrapped in gauze and that they had reported to staff #180 that staff #179 had caused them harm. A review of a complaint indicated there were concerns that after resident #023 had been admitted to the LTCH there were areas of altered skin integrity to identified areas.

In an interview, the complainant stated that shortly after resident #023 was admitted to the LTCH they noticed resident #023 had areas of altered skin integrity to identified areas and that their morale had plummeted.

A review of resident #023's health record indicated they had been admitted to the LTCH with an underlying health condition and associated impaired cognitive status. According to an assessment completed, resident #023 exhibited responsive behaviours. Documentation note entries indicated that on an identified date in April 2017, resident #023 was observed about to use their mobility aid to strike their roommate therefore their mobility aid was removed and replaced with an alternate mobility aid.

A further review of progress notes indicated resident #023 was noted to have a dressing in place to an area of altered skin integrity. According to a documentation note entry on the same day, staff #179 had reported that resident #023 had an area of altered skin integrity. This note further indicated that the altered skin integrity had occurred when a staff member had assisted resident #023 out of another resident's room.

A review of the home's investigation notes regarding the above mentioned incident indicated staff #179 heard a resident in an identified room making noise and went to investigate. Staff #179 found resident #023 sitting on another resident's bed in the room with their mobility aid in front of them. Staff #179 pulled the call bell for assistance and staff #161 came to assist. Staff #179 stated resident #023 began to exhibit responsive behaviours and was swinging their mobility aid.The mobility aid was removed and the resident was escorted from the room. Staff #179 stated they immediately noticed the altered skin integrity and reported it to the charge nurse.

In an interview, staff #179 admitted their hand had come down upon resident #023's upper extremity during the above altercation. In an interview, staff #161 recalled staff

#179 holding resident #023's upper extremity while they took the mobility aid away.

According to the home's investigation notes, staff #179 was given a discipline for the above mentioned incident.

In an interview, staff #105, acknowledged the home had failed to protect resident #023 from abuse by staff #179. [s. 19. (1)]

4. On February 28, 2018, a compliance order (CO) #001, from inspection #2018_493652_0011 was made under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) as follows:

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:

i) 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.

ii) to assess and provide residents with safe alternative tools for Activities of Daily Living (ADLs) i.e. metal grabbers, canes etc.

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

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

The compliance date was September 10, 2018.

During this inspection it was found that the home completed steps i, ii, and iv, but failed

to complete step iii.

A review of resident #018's progress notes indicated they had been transferred from the second to the fourth floor on an identified date in September 2018. Further review indicated resident #018 moved back to their room on the second floor on an identified date in October 2018.

In an interview, staff #156 stated the reason resident #018 was transferred to another room was because of a pest control issue the room needed to be treated. According to staff #156, this was a temporary transfer. Staff #156 was not aware that there was an interdisciplinary team approach to determine resident #018's suitability for the fourth floor as they assumed this had been completed by one of the DOCs and another nurse manager.

In an interview, staff #105 stated that an interdisciplinary approach was taken to determine resident #018's suitability to the fourth floor. Staff #105 indicated that the decision had not been documented to include the rationale for the decision, staff involved in the decision and the date. [s. 19. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A complaint was received by the MOHLTC indicating that when resident #001's SDM had been visiting they heard resident #001 exhibiting a responsive behaviour related to toileting. The PSW was overheard telling resident #001 they did not need to go. The SDM/complainant went to help resident #001 to the washroom and also reported the PSW had acted inappropriately towards resident #001. The incident was reported to the LTCH and it had been documented.

In an interview, resident #001's SDM stated as they exited from the elevator to the resident home area (RHA), they saw resident #001 asking staff for help to toilet, and the PSW saying, you are not going to use the washroom. While the SDM attempted to help the resident, a PSW stopped them as they could not help the resident. The SDM reported the incident to the nurse manager on the floor, and the manager indicated they would report it, and later on they said, that they had disciplined one of the staff members. The SDM indicated that it is the resident's basic right to use the bathroom.

A review of resident #001's current written plan of care indicated that staff are to toilet resident #001 twice a shift and when needed to ensure the resident is dry and clean. A review of the resident's clinical record and progress notes did not indicate documentation about the above mentioned incident.

In an interview, staff #103 stated that resident #001's SDM had raised a concern about continence care, and that the staff had reported they had just provided care to resident #001 and could not do it again. There was no reporting completed for the incident.

In an interview, staff #105 indicated that any alleged abuse and neglect incidents should be reported to the MOHLTC immediately and investigated. [s. 24. (1)]

2. A complaint was received by the MOHLTC related to a fall incident that had occurred in the shower room involving resident #007. The complainant stated resident #007 had been seated in a bathing assistive aid and when staff #166 was moving the bathing assistive aid over the floor lip into the shower area it tipped and both resident #007 and staff #166 fell onto the floor. The complainant further stated resident #007 had voiced to them that staff usually use an alternate bathing assistve aid and that two staff are usually present to move it over the floor lip safely however on this day, staff #166 was alone. Complainant stated they were concerned for any emotional trauma experienced by resident #007 related to this incident.

A review of the most recent health record under the activities of daily living (ADL) self care performance focus indicated that two staff are to transfer the resident to and from the shower stall with the use of the bathing assistive aid for safety.

In a conversation with resident #007, they remembered the fall incident in the shower had occurred but could not recall if an alternate bathing asisitive aid had been used. Resident #007 further stated they had not been injured in this incident and had no other subsequent injuries noted in the days afterwards.

In an interview, staff #166 acknowledged they had completed the transfer unassisted resulting in the fall and had been informed after the incident by staff #105, that the care plan indicated two staff are to be present when a bathing assistive aid is in use.

A review of the MOHLTC's critical incident system (CIS) on-line reporting and an interview with staff #105 indicated that a CIS report had not been submitted related to the above mentioned fall incident that involved improper care of resident #007 by staff #166.

In an interview, staff #105 acknowledged the home had failed to report this incident to the Director related to improper care of resident #007 that resulted in a fall incident and risk of harm to them. [s. 24. (1)]

3. The following evidence related to resident #009 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC regarding visitor/volunteer verbal and emotional abuse towards resident #009.

A review of an email communication provided by staff #183 to the inspector indicated staff #133 had received a complaint from resident #009 that visitor/volunteer #208 had spoken inappropriately to them in the courtyard regarding designated smoking areas. During an interview, resident #009 stated visitor/volunteer #208 had gotten close to them and had spoken inappropriately.

In an interview, staff #133 stated that after the incident in the courtyard, the home had sent visitor/volunteer #208 written communication regarding. Staff #133 acknowledged that the inappropriate conversation in the courtyard was abusive and they had failed to immediately report the incident to the Director. [s. 24. (1)]

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

Findings/Faits saillants :

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

Upon conducting observations related to temperatures in the home, the inspector

observed resident #016 unattended in a bathroom with a mobility transfer aid attached to them.

The inspector observed resident #016 alone in the bathroom seated on the toilet with a mobility transfer aid in place which was still attached to the mechanical lift. There were no staff members in sight however resident #016 indicated to the inspector they knew where the call bell was located. Staff #154 then entered the bathroom followed shortly by staff #155.

A review of resident #016's current plan of care indicated they needed extensive assistance from two staff for toileting and to assist with transferring to and from the bathroom with a mechanical lift.

In an interview, staff #154 stated they had only left resident #016 for a short period of time in order to call for another PSW to help with transferring. Staff #154 admitted they should not have left the resident alone attached to the mechanical lift.

In further interviews, staff #153, #152 and #130 stated that it is not safe for PSWs to leave residents unattended when attached to a mechanical lift. In an interview, staff #156 confirmed that staff #154 did not use safe positioning techniques when assisting resident #016. [s. 36.]

2. A CIS report was submitted to the MOHLTC indicating resident #017 was found with altered skin integrity to identified body parts on an identified date in September 2018.

A review of the resident #017's plan of care indicated they required one staff member to provide total assistance with care needs and the use of a mobility transfer aid for transfers.

A review of the home's investigation into what happened indicated that staff #162 had transferred resident #017 without the assistance of another staff member. In an interview, staff #162 stated they were aware that they should have had another staff member assist when transferring resident #017. Staff #162 stated they did not ask another staff member to help because everyone was busy. In an interview, staff #164 stated they had helped staff #162 transfer resident #017 from the bed to a bathing aid but had not helped with transferring the resident back to bed.

A review of the home's policy #VII-G-20.20(a) titled: Resident Transfer and Lift

Procedures last revised December 2017, indicated that two caregivers must be present during the lifting/transferring procedure when using a mechanical lift. Policy #VII-G-20.20(l) titled: Mechanical Lifting & Sling Safety Protocol states that when a mechanical lift is utilized, two staff members are required to perform the function. At no time is it permissible for only one staff to operate a mechanical lift.

In an interview, staff #105 confirmed staff #162 had not used safe transferring techniques when assisting resident #017 back to bed. [s. 36.]

3. A complaint was received by the MOHLTC related to a fall incident that had occurred in the shower room involving resident #007. The complainant stated resident #007 had been seated in a bathing assistive aid and that when staff #166 was moving the bathing assistive aid over the floor lip into the shower area it tipped and both resident #007 and staff #166 falling to the floor. The complainant further stated resident #007 had voiced to them that staff usually use an alternate bathing assistive aid and that two staff are usually present to move the chair over the floor lip safely, but on this day, staff #166 was alone. The complainant stated they were concerned for any emotional trauma experienced by resident #007 related to this incident.

A review of the most recent health record under the ADL self care performance focus indicated that two staff are to transfer to and from the shower stall with the use of the bathing assistive aid for safety.

In a conversation with resident #007, they remembered the fall incident had occurred in the shower but could not recall if the type of bathing assistive aid that had been used. Resident #007 further stated they had not been injured in this incident and had no other subsequent injuries noted in the days afterwards.

In an interview, staff #166 acknowledged they had completed the transfer unassisted and therefore the transfer had been unsafe. Staff #166 further stated staff #105 had provided re-instruction, informing them the transfer required two staff for safety as identified in resident #007's plan of care.

In an interview, staff #167 stated it was safe to say that an improper transfer had occurred with resident #007 as staff #166 had not provided care as per the plan of care as they had completed the transfer unassisted by a co-worker and as a result had been pushing the shower chair over the floor lip resulting in a fall incident.

In an interview, staff #105 acknowledged that by failing to provide care as per the plan of care, staff #166 had failed to use safe transferring and positioning devices or techniques when assisting resident #007. [s. 36.]

Additional Required Actions:

CO # - 003 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that the temperature of the water serving all showers used by residents was 49 degrees Celsius or less.

A CIS report was submitted to the MOHLTC that indicated resident #017 was found with altered skin integrity to identified body areas which required a transfer to hospital for further assessment.

In an interview, resident #017's SDM stated they were very upset that the home first told them the resident had only redness, then were told the resident was being sent to the hospital for further assessment. The SDM was told that the altered skin integrity happened during bathing when the water was not within normal ranges.

A review of resident #017's progress notes indicated the assigned PSW reported to the RN that they noted altered skin integrity to an identified body area. The RN went to assess resident #017 and noted areas of altered skin integrity. Resident #017 exhibited

discomfort while being moved during the assessment. The PSW told the RN the altered skin integrity was noted during their shower. The RN called the physician and received an order to send resident #017 to hospital. A review of a progress note on an identified date in September 2018, indicated the hospital told the LTCH that resident #017 had sustained multiple areas of altered skin integrity.

In an interview, staff #162 stated they had given resident #017 a shower and according to staff #162, they had checked the water temperature from the hand held shower head prior to beginning the shower and the temperature had been acceptable. Staff #162 first rinsed the resident and then hung the shower head on a shower bar while washing resident #017. Staff #162 did not check the temperature again as the water was still running and proceeded to rinse the resident. Staff #162 noticed resident #017 exhibit a responsive behaviour so they moved the water hose away from the resident and tested the water which was too hot and proceeded to reset the temperature and finished rinsing the resident. Staff #162 stated that they noticed the altered skin integrity when drying the resident. Staff #162 also indicated that fluctuating water temperatures had been an ongoing issue and was aware that it had been reported in the LTCH's electronic maintenance reporting system and to an identified floor manager who was also the LTCH's C-DOC.

In an interview, staff #163 stated the LTCH had been having issues with the water temperature on an identified side of the building for quite some time. Staff #163 further stated they did not think the LTCH had taken any action to deal with the water temperature issue until the incident with resident #017 happened. In an interview, staff #164 stated the water sometimes would get hot then goes back cold which had been a problem for a while.

In an interview, resident #018 stated that during their showers the water temperature would go back and forth and the staff have to make adjustments. In an interview, resident #019 stated that the water temperature would get hot then cold, was always changing and the staff were always checking.

A review of Maintenance Care Communication from the floors indicated that water temperatures on an identified side of the building had been an ongoing issue since June 14, 2018 as follows:
•June 14, 2018: Not enough hot water, sixth floor, north side shower room,
•June 15, 2018: Only cold water in north shower room, sixth floor,
•June 19, 2018: Water won't stay warm during shower. Five minutes it is warm then turns

cold even when we turn the knob to full hot. Happening morning and evening showers. Ongoing. PSWs unable to give showers as it turns cold during showers. 6th floor north side shower room. Submitted by Nurse Manager/DOC #105,
•July 12, 2018: No hot water in north side shower room on sixth floor,
•July 19, 2018: North side shower we are only getting cold water third floor,
•July 22, 2018: North side shower room we do not have hot water only at the face basin, none in shower, third floor,
•July 30, 2018: Shower temperature is not hot enough north shower room on second floor,
•August 1, 2018: The water is not getting hot enough for residents to take shower. It's cold. North side shower, fifth floor,
•August 6, 2018: Daughter complained that when water is turned on (cold or hot) it's either really cold or really hot and that it is never just warm, washroom sink on third floor (room 307 on the north side),
•August 21, 2018: Shower room water cold no hot water, sixth floor, and
•August 27, 2018: Shower room water cold no hot water, sixth floor.

A review of the home's policy #VII-H-10.70 titled: Water Temperature Monitoring last revised July 2015, indicated that the temperature of the hot water serving all bathtubs, showers, and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed 49 degrees Celsius and will be monitored daily once per shift in random locations where residents have access to hot water.

In an interview, staff #135 who works two days a week at the home since an identified date in July 2018, stated they were aware of issues with the water temperatures and stated that the maintenance supervisor would often go onto the roof to adjust the mixing valve. According to staff #135, maintenance takes temperatures in all shower units once a day. A review of the daily maintenance checklist from September 16, 2018, to September 22, 2018, indicated the water temperature in the 6th floor shower room was 48 degrees Celsius every day. All other floors had water temperatures within the range of 40 to 49 degrees Celsius. There were no daily maintenance checklists provided for September 23, 2018.

In an interview staff #105 admitted that nursing staff had not been monitoring water temperatures each shift in random RHAs. Staff #105 stated that nursing staff were not using the form titled Resident Care Area Water Temperatures and were using the 24 hour shift report to document water temperature readings and were doing so only intermittently. According to staff #105, nursing were not monitoring water temperatures

according to the home's policy.

In an interview, staff #133 stated that a staff member had brought to their attention sometime in late August 2018, that staff had been reporting no hot water on the north side of the building and that nothing was being done about it. According to staff #133, a plumbing contractor was brought in August 24 and 25, 2018, and the issue had been resolved by diverting water from the tubs. However, the LTCH learned after the incident with resident #017, that there was a problem with the mixing valve which needed to be replaced. Staff #133 acknowledged that because they do not have a dedicated manager of the maintenance department, there was no one overseeing the maintenance requests on their electronic system known as Maintenance Care. Staff #133 also acknowledged that the home had not been monitoring water temperatures daily once per shift in random locations where residents have access to hot water. [s. 90. (2) (g)]

Additional Required Actions:

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

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

The MOHLTC received complaints related to falls prevention and management and plan of care for resident #005 on three identified dates

A review of resident #005's progress notes indicated that the resident underwent an elective procedure and following readmission to the LTCH had been assessed by physiotherapy (PT) to require a mechanical lift for transfers. Resident #005's written care plan had been updated in pen to indicate this change in resident #005's transfer status. The manual update had not been signed or dated.

A review of resident #005's kardex indicated that the information related to their transfer status was a template statement that had not been updated to specify the resident #005's assessed transfer care needs.

In an interview, staff #111 stated that resident #005 transferred with a two person manual assistance, and that they had transferred the resident with a second PSW using two person manual assistance on an identified date in September 2018. Staff #111 further stated they had referred to resident #005's kardex and then checked the resident's closet door for their transfer logo prior to performing the transfer. Staff #111 indicated that resident #005's posted transfer logo posted indicated two person manual assistance for transfers. Staff #111 also stated that there had been no issues with resident #005's manual transfer.

While observing resident #005's kardex together with the inspector, staff #111 confirmed that the kardex had not been updated to include specific information regarding resident #005's transfer status. They indicated further that they did not know if there was anywhere else they could look to access the information that was missing from the kardex.

In an observation, staff #111 showed the inspector the transfer logo posted in resident #005's room which depicted an image of manual assistance of two staff for transfers.

In an interview and during observations, staff #100 stated that it was the responsibility of the nursing staff to update residents' transfer logos if a change in transfer status had been recommended by the PT. They confirmed that resident #005 required a mechanical lift for transfers, that the transfer logo had not been updated in resident #005's room, and that if a two person manual transfer was performed then the resident's care plan had not been followed.

In an interview, staff #103 confirmed that if a resident requires a mechanical for transfers and the transfer logo indicated staff are to use manual assistance with two people, then it would be considered unclear directions to staff and the transfer could be considered unsafe. [s. 6. (1) (c)]

2. The licensee has failed to ensure the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A complaint was received by the MOHLTC from resident #009 regarding a specific incident where staff #167, when providing care, pulled on their clothing causing it to rub against an identified body area resulting in resident #009 exhibiting responsive behaviours towards staff #167. Resident #009 indicated in the complaint that they were not to be touched due to a previous traumatic incident that has occurred while living in the community.

A review of resident #009's health record indicated they had been admitted to the LTCH with underlying health conditions that could contribute to exhibiting responsive behaviours.

A review of a behavioural assessment tool (BAT) completed on an identified date in August 2016, indicated responsive behaviours that resident #009 was known to exhibit.

In an interview conducted by an inspector, resident #009 stated they had communicated to the LTCH on admission and in recent months their specific care need preferences.

A review of the most recent plan of care indicated a behavioural focus and a mood focus related to responsive behaviours exhibited by resident #009. The plan of care did not address resident #009's needs and preferences as indicated above.

In an interview, staff #167 stated they had not been aware of resident #009's specific care need preferences and after reviewing the plan of care noted these specific care need preferences had not been care planned. In an interview, staff #175 stated they had not been aware of resident #009's specific care need preferences.

In an interview, staff #105 stated that with resident #009 it is important to have created a plan of care based on an assessment of their needs and preferences and acknowledged the LTCH had failed to do so. [s. 6. (2)]

3. The licensee has failed to ensure the resident, the SDM, if any, and the designate of the resident / SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

a complaint was received by the MOHLTC related to resident #026 regarding multiple care concerns. In a phone conversation with an inspector, SDM #202 stated the home's physiotherapist had recommended the use of a specific mobility aid instead of the one currently in use as resident #026 had not been consistently engaging the locking mechanism increasing their risk of falls.

In an interview, SDM #202 stated the home was to source out this specific mobility aid and staff #106 was to have followed up with them. In a phone conversation SDM #202 further stated they had not heard back from staff #106 about the above mentioned mobility aid at the time of this inspection.

In an interview, staff #114 stated they had sourced the specific mobility aid however it was not covered under the assistive devices program (ADP). Staff #114 further stated they had provided this information to staff #106 and assumed they had communicated this information to SDM #202 providing an opportunity for them to participate fully in making a decision in the development and implementation of the plan of care.

Staff #106 no longer works in the home and therefore an interview was not conducted.

A review of resident #026's documentaion notes did not indicate any entries from staff #106 under family discussions with SDM #202 centered on this mobility aid. In an interview, staff #105 acknowledged they had not been aware that staff #105 had not provided SDM #202 with the information and therefore the opportunity to participate fully in the development and implementation of the plan of care. Staff #105 stated they would follow-up with SDM #202. [s. 6. (5)]

4. A complaint was received by the MOIHLTC related to falls prevention and management for #005. The MOHLTC also received a CIS report related to a fall with injury for resident #005.

In an interview, the complainant stated that neither family contact had been notified about resident #005's fall until 12 hours after the incident had occurred. They indicated that the LTCH had said someone called the primary contact at a specified time however, they had no voicemails or missed calls from the LTCH.

A review of resident #005's profile indicated a phone number for their primary contact, as well as phone numbers for their secondary contact. An icon beside the primary contact's name indicated additional information had been added to contact alternate family member regarding any health status issues or changed behaviours at any time.

A review of resident #005's progress notes indicated that staff #110 had documented that they had not attempted to contact resident #005's SDM to notify them about resident #005's incident and had endorsed to the oncoming staff as it was too early to call. Staff #108 documented during their shift that they had notified resident #005's SDM about the fall incident via a voice mail message. The note indicated resident #005 was experiencing some discomfort as indicated on the pain scale, and was exhibiting responsive behaviours toward staff during care. The physician was notified regarding the resident's status post-incident and an order was given to send resident #005 to hospital. Resident #005 was transferred to hospital and their SDM was notified at that time.

In an interview, staff #108 stated that family members would be notified after any fall incident. Staff #100 indicated that if the fall occurred on an identified shift, that nurse may ask the oncoming shift nurse to notify the family; however, if it happened during daylight hours, family members should be notified as soon as the nurse was finished assessing the resident, within approximately 30 minutes. Staff #108 further stated they were working on the next shift after the fall incident and the outgoing nurse had endorsed the notification of family to them. Staff #108 called the primary contact at two identified times that morning, however they later found out and notified the SW that the contact number on resident #005's electronic file was not the current contact number for that person. They further stated they had not known this number was not an active phone number, so they had given the primary contact time to call back and that they had not tried calling the secondary contact. Upon their next set of assessments for resident #005, staff #108 realized the primary contact had not called back, and that resident #005's status was changing. At this time, staff #108 stated they called the secondary contact to inform them that resident #005 had sustained a fall on the previous shift and that they would be sending them out to hospital. Staff #108 also stated that there had been some time that had gone by when all of this occurred, and that it was not typical for this identified amount of time to go by post-fall without the SDM being notified.

In an interview, resident #005's primary contact, stated they had discontinued their home phone line in June of 2017, but that their alternate phone number had remained the same. They further indicated they had notified staff #147 at the time the change was

made.

In interviews, staff #132 and staff #147 stated they were responsible for keeping resident's contact information up to date. They confirmed there was no audit history available on the program to indicate when someone's contact information may have been updated. Staff #147 could not remember if resident #005's primary contact information had changed over the last year, and staff #132 stated that they had not been informed of any changes to the telephone contact information for resident #005's primary or secondary contact in 2017.

In an interview, staff #105 stated that to their knowledge, there was no indication that the contact information for resident #005's SDM had changed. Staff #105 confirmed that when a resident has a fall on an identified shift, the family should be notified right away in the morning, that 14 hours post-fall was an unreasonable time delay, and that when the primary contact was not available the secondary contact should be tried. Staff #105 confirmed further that resident #005's family had not been given the chance to participate fully in the plan of care, and staff #108 had been disciplined for not informing the family about the resident's fall and change of status right away. [s. 6. (5)]

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

A complaint was received by the MOHLTC related to the care and treatment of resident #001's altered skin integrity. The complainant stated resident #001's altered skin integrity had been progressively worsening, resident #001 was exhibiting responsive behaviours, that an identified substance was being put on their altered skin integrity and home staff were giving them medication and not addressing the real issues. The complainant also stated they had brought their concerns forward, asking why resident #001's treatment had not been more aggressive, however, because they were not the SDM the LTCH was not providing any information to them.

Resident #001 was admitted to the home with underlying health conditions, one of which included altered circulation to their extremities. A review of the documentation notes on an identified date in May 2018, indicated a new onset of altered skin integrity. A review of the current written plan of care indicated a focus for the altered skin integrity related to altered circulation to their extremities had been initiated by staff #100. The written plan of care indicated a scheduled medication for pain management was to be administered and not to cover or apply any dressing on the altered skin integrity as per the SDM's

request.

Observations by the inspector indicated resident #001's altered skin integrity had been covered and placed in a pressure off-loading aid while they were up in a wheelchair.

In an interview, staff #100 stated that resident #001's altered skin integrity was not to be covered as per the SDM's request and as noted in the plan of care. When the inspector showed staff #100 resident #001's altered skin integrity covered, they acknowledged care was not being provided as per their plan of care.

In an interview, staff #121 acknowledged assisting staff #123 with providing care to resident #001 on an identified date in August 2018, but denied they had covered the altered skin integrity. In an interview, staff #123 stated they were aware that resident #001's altered skin integrity was not to be covered however, on the above mentioned shift, while providing care, the altered skin integrity had been discharging fluid. Staff #123 further stated that staff #121 had suggested to cover the altered skin integrity and subsequently staff #123 agreed even though they were aware they were not providing care as per the plan of care.

In an interview, staff #103 acknowledged that staff #121 and #123 had failed to ensure the care set out in the plan of care had been provided to the resident #001 as specified in the plan.

6. The following evidence related to resident #024 was found under inspection report #2018_626501_0021.

A review of resident #024's written plan of care indicated that resident #024 required total assistance from two people for turning and repositioning in bed.

Staff #157 further stated they had provided care to resident #024 three times during the night shift unassisted as there had been no other PSW working on that side to assist with the task. Staff #157 confirmed they are expected to follow a resident's plan of care when providing care.

In an interview, staff #121 stated that if a resident required two people assistance, they need to wait for another PSW to assist. Staff #121 confirmed they are expected to follow a resident's plan of care when providing care.

In an interview, staff #100 stated that the PSWs are expected to follow a resident's plan of care when providing care.

In an interview, staff #105 stated that PSWs should have followed resident #024's the plan of care and had two staff assist with turning and repositioning the resident as indicated in their plan of care. [s. 6. (7)]

7. During observations of resident #005 while in bed, the inspector noted the safety pad on one side of the bed placed on the floor while the second safety pad was noted to be in an upright position with the resident's mobility aid propping it upright against the side of the bed like a barricade.

A review of resident #005's written plan of care indicated that safety pads are to be placed on the floor on both sides of their bed when they are in bed. A review of resident #005's physician's orders and an assessment failed to indicate the presence of any interventions as restrictive aids or assistive aids.

In an interview, staff #111 stated resident #005 required the use of safety pads which were to be placed on the floor near the bed. Staff #111 further stated they had received resident #005 in bed from the previous shift, and that this was the first time they had observed the safety pad to be set up in this manner. They further indicated that resident #005 may have been trying to get up from bed and the staff may have been trying to block them. Staff #111 indicated they assumed it was for falls prevention as the resident would try to ambulate on their own. Staff #111 confirmed that it could have been a restrictive aid however, they left it in place because they were trying to prevent resident #005 from being injured again, and that they had not notified the registered staff.

In an interview, staff #157, who was assigned to the resident's care on the previous shift stated they worked part-time and could not recall resident #005 and did not remember ever propping up a safety pad to block the side of a resident's bed.

In interviews, staff #100 stated that resident #005 tended to self transfer and staff #112 stated resident #005's written care plan outlined that safety pads should be in place when they were in bed. Staff #112 further stated that no one had brought to their attention that resident #005's safety pad was set up in a vertical position with the mobility aid supporting it in place, and that this would be considered restrictive and should not have been done.

In interviews, staff #103 and #105 confirmed that if home staff were blocking a resident's bed with an upright safety pad and mobility aid, then the care set out in the plan of care had not been provided to resident #005 as specified in their plan. [s. 6. (7)]

8. The licensee has failed to ensure that the staff and others who provide direct care to the resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

Three complaints were received by the MOHLTC related to resident #005.

Upon initiating the on-site inspection, the inspector was provided with two separate log-ins for the home's electronic documentation system; one to be accessed for information prior to an identified date in August 2018, and one to be accessed for information after the identified date in August 2018. The inspector was also notified that printed care plans were available in binders at the nursing station on each unit which staff were to access until the transition from the former electronic documentation system to the latest electronic documentation system was complete and all residents' current care plans were online.

A review of resident #005's written care plan on the latest Point Click Care (PCC) system indicated that the resident's care plan and kardex were incomplete. A review of the written care plan printed on an identified date in August 2018, for resident #005, located in a binder on the unit, indicated that staff had been updating care plan interventions in writing on the paper document.

In an interview, staff #112 stated they had just returned from being off and had been notified that care plans had changed and were no longer in the computer. Staff #112 further stated they were unaware as to whether the care plans were printed or accessible elsewhere, and was awaiting training regarding the changes to the home's electronic documentation records.

In an interview, staff #111 stated that they refer to the kardex in the electronic POC system to determine a residents' care needs. Staff #111 further stated they did not know if there was anywhere else they could access the information that was missing from the kardex.

In an interview, staff #156 stated that the home's electronic documentation system had changed over on an identified date in August 2018, and that head office staff had come

to train all of the home's full-time staff and the majority of registered staff with staff #156 contining the training for the remaining staff. Staff #156 confirmed that it had been communicated to all staff during the training that care plans would be printed and accessible in binders on the unit until the transition was complete.

A review of staff training records for staff #111 and staff #112 indicated that both of these staff members had received the training. A review of the staff training on care plans in PCC's new "ssli" database indicated that printed care plans from the unit's prior PCC "lwca" database would be available for reference.

In an interview, staff #156 confirmed that all direct care staff had received the training.

In interviews, staff #103, #156, and #105 confirmed that all staff should be kept aware of the contents of plans of care, have convenient and immediate access to it, and know where to locate them. [s. 6. (8)]

9. Three complaints were received by the MOHLTC related to falls prevention and management for resident #005.

A review of resident #005's written plan of care printed on an identified date in August 2018, indicated that mobility sensors were to be applied to their mobility aid when up and to their bed when in bed. Another intervention stated to apply an additional mobility sensor at all times. A review of the resident's most recent falls risk assessment indicated they were at high risk for falls.

An observation by the inspector of resident #005 noted the additional mobility sensor was placed on top of their mattress, and not clipped to the resident while they were sleeping in bed. Throughout the course of this inspection the inspector only observed the additional mobility sensor in the resident's bed and wheelchair.

In an interview following the observation, staff #111 stated resident #005 required a mobility sensor while in bed and confirmed that it had not been clipped to the resident at the time of this interview. Staff #111 further stated they had applied the additional mobility sensor to resident #005 at the start of their shift and had since checked and reapplied it three times between a three hour period, as resident #005 was capable of removing the clip without it ringing. Staff #111 also stated that maybe they could give resident #005 another type of mobility sensor.

In an interview, staff #112 stated that resident #005 was at high risk for falls and required mobility sensors while in bed and in their mobility aid. Staff #112 further stated that earlier on their rounds they had observed the mobility sensor clipped to resident #005, however, later it had separated and made a sound, which they responded to by reattaching to the resident.

An observation conducted by the inspector on a subsequent day indicated resident #005's mobility sensor was unclipped while the resident was seated up in their mobility aid. The inspector questioned nearby staff #161 about the unclipped mobility sensor who indicated that they were not the assigned caregiver for resident #005, but assumed that if it was on the mobility aid that it should be clipped to the resident. Staff #161 was observed to then clip the mobility sensor to resident #005.

In an interview, staff #100 stated resident #005 was at risk for falls, required mobility sensors to their bed and mobility aid for falls prevention, and that they had been one of the staff to respond to a fall incident for resident #005 on an identified date in September 2018. Staff #100 stated that when they observed the resident post-fall, the mobility sensor was noted to be on the bed, but that it had not sounded because it had not been clipped to the resident. Staff #100 further stated that they were certain resident #005 had removed the mobility sensor themselves since they had witnessed the resident remove it on another identified occasion.

In interviews, both staff #100 and staff #112 stated they were not aware as to whether another type of mobility sensor had been tried with this resident. Staff #100 further stated that they planned to document they had witnessed resident #005 remove their mobility sensor, that maybe they could try an alternate type of mobility sensor with this resident, and that the current mobility sensor in place had not been effective.

In an interview, staff #144 stated resident #005 had mobility sensors to their bed and mobility aid, and that to their knowledge they had been effective as staff had not reported to them otherwise. Staff #144 confirmed that if resident #005 had been unclipping the mobility sensor then it would not be effective at alerting staff regarding falls and injury prevention.

In an interview, staff #103 indicated that resident #005 had mobility sensors in their bed, on their mobility aid, and a new floor mobility sensor which had been provided earlier that month. Staff #103 confirmed resident #005 was able to unclip their mobility sensor and it had reached its limit for effectiveness. Staff #103 further stated that resident #005's bed

mobility sensor had been in place for some time, but that they could not provide a specific date. Staff #103 indicated that the home did not keep a record of the equipment that had been loaned to residents and when, nor did they audit the equipment that had been supplied to residents for falls prevention.

In an interview, staff #105 confirmed that if a resident was continuously unclipping their mobility sensors, then the intervention would not have been effective and alternatives should have been tried. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the following:
-to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident,
-to ensure that the staff and others who provide direct care to the resident is kept aware of the contents of the plan of care and have convenient and immediate access to it,
-to ensure the resident, the SDM, if any, and the designate of the resident / SDM is provided the opportunity to participate fully in the development and implementation of the plan of care,
-to ensure that the resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care is not effective, and
-to ensure the care set out in the plan of care is provided to the resident as specified in the plan,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

Three complaints were received by the MOHLTC related to falls prevention and management, plan of care, skin and wound care, and responsive behaviours for resident #005.

On multiple occasions during the course of this inspection, resident #005 was observed to be seated in their mobility aid in various positions.

A review of the resident's written plan of care, physician's orders as of an identified date in September 2018, and an assessment completed, failed to reveal the presence of an intervention for use of a specific mobility aid as a restraint or personal assistance services device (PASD).

In interviews, staff #126 stated they had altered the position of resident #005's mobility aid when the resident was exhibiting responsive behaviours as they would get up if left. Staff #111 also stated that resident #005 uses a specific mobility aid, that they ask resident #005 if they want their position altered in order to provide greater comfort to them and prevent them from exhibiting responsive behaviours. Staff #111 confirmed that the use of this specific mobility aid as a PASD or restraint was not outlined on resident #005's kardex.

In an interview, staff #112 stated resident #005 uses a specific mobility aid, and that they should not be altering the resident's position beyond an identified amount for comfort unless they had a physician's order and the family's permission. Staff #112 confirmed that there was nothing outlined in the resident's plan of care about use of a specific mobility aid.

In an interview, staff #100 stated they had observed staff altering the position of resident #005's mobility aid at varying degrees, and confirmed that there was nothing outlined in the resident's plan of care.

In an interview, staff #103 stated resident #005 had been recently assessed, over the past week, for use of their specific mobility aid as a PASD, and that they had seen

resident #005's mobility aid being repositioned prior to that assessment. They indicated that the resident's mobility aid was being repositioned because they were exhibiting responsive behaviours.

In an interview, staff #105 confirmed that if a resident's mobility aid was being repositioned as a PASD or restraint then the physician would write an order, it would be in the care plan, and reassessed every three months. [s. 33. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a PASD describe in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A complaint was received by the MOHLTC related to skin and wound care for resident #005.

A review of resident #005's progress notes indicated that the resident had a history of altered skin integrity to their body and that multiple treatments had been prescribed by the resident's physician. Resident #005's written care plan indicated that the resident had altered skin integrity to their body and that staff were not to offer the resident identified foods.

In an interview, staff #109 stated that resident #005 has had areas of altered skin integrity since an identified date in May 2018, that the resident was followed by the physician and that multiple treatments had been tried to address the areas of altered skin integrity.

In an interview, staff #102 stated that they sometimes receive referrals regarding residents with this type of altered skin integrity but that their nutritional intervention options are limited. Staff #102 confirmed they had not received any referrals for resident #005 and that in this case, a referral for an assessment probably should have been made. Staff #102 confirmed that food sensitivities were only one of many potential causes and that resident #005 had not been provided with any of the identified foods that they had a known dislike or sensitivity toward.

In an interview, staff #156 stated that if other treatments were not working for resident #005's altered skin integrity then a referral should have been made to the RD.

In interviews, staff #156, #103 and #105 confirmed that resident #005 had not been referred to the RD related to their altered skin integrity. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

a.)A complaint was received by the MOHLTC related to resident #026. In a phone

conversation, SDM #202 stated the resident had been experiencing altered skin integrity to an identified body area for quite some time.

A review of resident #026's health record indicated a physician's order for a medicated treatment was to be applied topically as ordered to the affected area. A review of the treatment administration records (TAR) for the past quarter indicated the above mentioned treatment was being applied two times per day as ordered.

In an interview, staff #120 stated resident #026's altered skin integrity would have required weekly assessments to determine the effectiveness of the physician ordered treatment. Staff #120 further stated the weekly skin assessments would be completed under the assessments tab in PCC, however since the home had adapted PCC One Record on an identified date in August 2018, they were not sure where to document weekly skin assessments.

A review of the assessments tab from the previous point click care (PCC) documentation system indicated the last weekly skin assessment had been completed on an identified date in July 2018. A further review indicated no other weekly skin assessments had been completed in the previous PCC system. On an identified date in October 2018, in the new PCC One Record's progress notes for resident #004 under the focus of skin-weekly skin summary, a skin assessment had been completed for the altered skin integrity in their inguinal area 13 weeks after the last documented assessment.

In an interview, staff #151 who is also the wound care nurse in the LTCH stated that registered staff are required to document weekly for any areas of altered skin integrity and that resident #004's altered skin integrity required weekly skin assessments to monitor the effectiveness of the treatment in place. Staff #151 further stated they had recently been providing education to registered staff on where to document weekly skin assessments in PCC One Record.

In an interview, staff #120 acknowledged that weekly skin assessments had not been completed for resident #004 for a period of 13 weeks as they had been unsure where to document in the new PCC system however further stated they had recently received education on where to document weekly skin assessments in the new PCC system. A review of an education in-service sign-in sheet from an identified date in October 2018, indicated staff #120 had received the above mentioned education on this date.

In an interview, staff #156 acknowledged the LTCH had failed to ensure resident #026's

altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

3. b.) A review of resident #005's progress notes indicated that the resident had a history of altered skin integrity to multiple areas dating back to at least June 2018, and that multiple treatments had been prescribed by the resident's physician during that time to address the condition. Resident #005's written care plan indicated that the resident had altered skin integrity with an intervention for a weekly skin assessment to report for any changes improvement/worsening of the areas of altered skin integrity. A review of the physician's orders for resident #005 indicated the resident had been prescribed two specific courses of treatments beginning on identified dates in August 2018, and September 2018.

A review of resident #005's weekly skin assessments indicated there was no evidence of weekly skin assessment having been completed for altered skin integrity between identified dates in August 2018 and September 2018.

The inspector observed multiple areas of altered skin integrity to identified body areas on resident #005. On an identified date in October 2018, resident #005 was observed seated in their mobility aid exhibiting responsive behaviours related to their areas of altered ski integrity.

In an interview, staff #109 indicated that if a resident had altered skin integrity their skin would be assessed weekly and as needed. Staff #109 further stated that resident #005 has had altered skin integrity to identified areas of their body since at least May 2018, and that the resident required weekly skin assessments and was referred to the physician each time their condition seemed to change. Staff #109 confirmed that resident #005 had not received a weekly skin assessment between identified dates in August 2018 and September 2018, following transition to the new PCC documentation system.

In interviews, staff #103 and #156 stated that altered skin integrity required weekly skin assessments. Staff #156 confirmed that resident #005 required weekly skin assessments to monitor their altered skin integrity especially because they were receiving a physician prescribed treatment.

In an interview, staff #105 confirmed that residents with altered skin integrity should receive weekly skin assessments in order to determine the effectiveness of the treatment provided. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented and to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A complaint was received by the MOHLTC related to resident #015. The complainant stated they had concerns related to one recent incident where they felt had not been taken care of in a timely manner.

A review of documentation notes for resident #011 and #015 indicated an incident had occurred on an identified date in August 2018, where resident #015 was found to be touching resident #011 inappropriately.

A review of resident #011's health record indicated they exhibited responsive behaviours but did not provoke altercations with other residents.

A review of resident #015's health record indicated they exhibited responsive behaviours which included wandering into other resident's room and sleeping in their beds, and towards others and staff.

In an interview, staff #173 stated they have had resident #015 under their care on and off for responsive behaviours exhibited. Staff #173 further stated they were aware of the above mentioned incident and had previously recommended if resident #015's responsive behaviours escalated to initiate one to one (1:1) staffing supervision. Staff #173 also stated that the home should have initiated 1:1 staffing supervision after the above mentioned incident as this represented as a new responsive behaviour being exhibited by resident #015.

In an interview, staff #108 stated they had been working on an identified date in August 2018, and recalls the incident being reported to them by staff #101. Staff #108 further stated they had reported the incident to staff #184 who then gave direction to staff #108 on what actions were to be taken at that time which included initiating an observation tool. Staff #108 stated they thought attempts were made to initiate 1:1 staffing but could not remember if this had actually been initiated. The observation tool that had been initiated but could not be located in resident #015's health record. Attempts by staff #105 and #172 to locate the observation tool during this inspection were unsuccessful.

In an interview, staff #184 stated they vaguely recalled the incident being reported to them by staff #108. Staff #184 verified they had been working on this date as the nurse manager in charge however on this day had been providing resident care on another floor. Staff #184 stated since resident #011 had not sustained any injury they had only given direction to staff #108 on what actions to take. Staff #184 could not recall if any attempts to call staff in to initiate 1:1 staffing had occurred and acknowledged that initiating the observation tool had not been sufficient to monitor this new responsive behaviour being exhibited by resident #015. Staff #184 stated they had called the DOC on-call but could not recall if they had asked for 1:1 staffing approval.

In an interview, staff #105 stated resident #015 had a history of exhibiting responsive behaviours however the above mentioned incident indicated a new responsive behaviour being exhibited that required increased monitoring. Staff #105 further stated every hour monitoring on the observation tool initiated for resident #015 had not been sufficient increased monitoring due to the severity of their actions towards resident #011 therefore, acknowledging the licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (1) The licensee shall ensure that there is a designated lead for each of the housekeeping, laundry services and maintenance services programs, but the same person may be the designated lead for more than one program. O. Reg. 79/10, s. 92 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated lead for the maintenance services program.

In relation to non-compliance under O.Reg 79/10 s.90.(2) (g), the designated lead for the maintenance services program was reviewed.

In an interview, staff #135 stated they had started working at the LTCH two days a week since an identified date in July 2018. In an interview, staff #133, stated that a consultant from Building Services Business Partner, worked at the LTCH three or four days a week.

Staff #133 acknowledged that even though they try to oversee the maintenance services program, they had not been able to do so effectively and confirmed that the LTCH had not had a designated lead for the maintenance services program since June 2018. [s. 92. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a designated lead for the maintenance services program, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A complaint was received by the MOHLTC that indicated the complainant had concerns

related to two recent incidents from the past two months that they felt had not been taken care of in a timely manner. One of these incidents was identified by the complainant as an incident from an identified date in August 2018, where resident #015 had been found touching resident #011 inappropriately while they were in bed.

During a phone conversation with an inspector the complainant indicated they had received a phone call from the home indicating the above mentioned incident had been nothing to worry about. The complainant further indicated that it was at the end of a two hour meeting held with staff #106 where they disclosed the actual events of the incident that had occurred three days earlier. As per the phone conversation the complainant stated they ended the meeting with staff #106 as they were very upset about not being notified of the actual events and asking why the police had not been notified.

Staff #106 no longer works in the home and therefore an interview was not conducted

In an interview, staff #108 stated they did not recall if the police were notified and was not certain if the NM had called.

In an interview, staff #184 stated they had informed the weekend DOC of the incident but had not called the police. A review of the weekend roster for the identified date in August 2018, indicated staff #105 had been the DOC on call that day. A review of staff #184's weekend report to staff #105 did not indicate that an incident had occurred between resident's #011 and #015.

In an interview, staff #105 stated they had found out about the above mentioned incident when they had overheard a conversation between staff #106 and #133 where staff #106 acknowledged that resident #011's SDM had been upset about not being informed of the actual events until three days later and that the police had not been called.

A review of the documentation notes indicated the police came to the LTCH three days after the incident however the LTCH could not provide any documentation of the outcome of their visit. A further review of the documentation notes did not provide any indication of the outcome of the police investigation related to this incident.

In an interview, staff #105 acknowledged that even though resident's #015 and #011 had impaired cognition, the police should have been called to determine criminal intent. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to the person who made the complaint indicating what the licensee had done to resolve the complaint for every written or verbal complaint made to the licensee or staff member concerning the care of a resident.

A CIS report was submitted to the MOHLTC that indicated resident #017 was found with altered skin integrity to identified areas of their body requiring transfer to hospital for further assessment. The MOHLTC also received a complaint from resident #017's SDM regarding the altered skin integrity.

In an interview, resident #017's SDM stated they were told that resident #017 sustained altered skin integrity to their body during care where the water got too hot. According to the SDM, they were told by staff #133 that they could get a report of what happened and sent a request for this via email. At the time of this inspection the SDM had not heard back from staff #133.

In an interview, staff #133, stated they were not aware that resident #017's SDM had made a complaint. Staff #133 remembered having a meeting with resident #017's family members, but did not recall any written communication. After staff #133 reviewed their email communication, they discovered an email from resident #017's SDM requesting information regarding the above mentioned incident. According to staff #133, they had missed this email and had failed to respond to resident #017's SDM regarding their complaint. [s. 101. (1) 3. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a response is made to the person who made the complaint indicating what the licensee has done to resolve the complaint for every written or verbal complaint made to the licensee or staff member concerning the care of a resident, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the long term care home ensured the resident, the resident's substitute decision-maker, if any, and any other person that either of them may direct were given an opportunity to participate fully in the conferences.

A complaint was received by the MOHLTC related to resident #026 in regards to multiple care concerns. The complaint further indicated resident #026 had been admitted to the home on an identified date in January 2018, and that an admission care conference with family had not been conducted as of date of this complaint.

A review of resident #026's health record indicated a care conference had been conducted on an identified date in January 2018, with the physician, a nurse manager, the dietary services supervisor (DSS) and a RAI-MDS coordinator being present. The health record further indicated no family had been present at this care conference.

In an interview, staff #132 stated admission care conferences are usually discussed on the day of a resident's admission and if not, within the first three days of admission, a letter is sent to the family with the date and time, and a reminder phone call is placed by reception the day before the booked care conference.

A review of the care conference calendar for January 2018, did not indicate a care conference had been booked for resident #026. Also, staff #132 was not able to provide the letter sent to resident #026's SDM #202 confirming the care conference date. Staff #132 further indicated care conferences letters are sent to families by reception staff and

was not certain if copies were saved.

In an interview, staff #134 stated they do not save care conference letters and they do not keep a record of reminder care conference phone calls made to families.

In a phone conversation, SDM #202, stated they had not been aware of a care conference booked for an identified date in January 2018, nor had this date been discussed on admission or thereafter. As well, SDM #202 further stated they had not received a letter nor a reminder phone call regarding the admission care conference.

A review of resident #026's progress notes and an interview with SDM #202 indicated the admission care conference was held on an identified date in March 2018, seven and half weeks after admission.

In an interview, staff #132 acknowledged the January 2018 care conference calendar had not indicated a care conference had been booked for resident #026 and that there was no documented record a care conference letter had been sent nor that a reminder phone call prior to the scheduled date had been completed. Staff #132 would not verify with a yes or no, only stating it appeared the care conference process had not been adhered to for resident #026. [s. 27. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

In relation to non-compliances under O. Reg. 79/10, r. 36, under this inspection the falls prevention program evaluation was reviewed.

In interviews, staff #156, the current falls prevention program lead, and staff #105 stated that they were unable to locate a falls program evaluation from 2017. Staff #156 stated that they were new to the role as of September 2018, and that they had also been looking for a previous program evaluation without success.

Staff #105 provided the inspector with two quarterly reviews for the falls and restraint committee dated on identified date in April 2017 and July 2017, which indicated the only participant was the former falls prevention lead, who no longer works in the LTCH.

Staff #105 confirmed that they were unable to locate any evidence of an interdisciplinary falls prevention program evaluation having been completed for 2017. [s. 30. (1) 3.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A complaint was received by the MOHLTC where the complainant indicated they had concerns related to two recent incidents over the past two months that they felt had not been taken care of in a timely manner. One of these incidents was identified by the complainant as an incident from an identified date in August 2018, where resident #015 had been found touching resident #011 inappropriately while they were lying in bed.

During a phone conversation with an inspector, the complainant stated they had received a phone call on an identified date in August 2018, from the LTCH indicating an incident had occurred between resident #011 and #015 but, there was nothing to worry about. The complainant further stated they had not been informed about what actually has occurred until they had a meeting with staff #106 who disclosed the actual events of the above mentioned incident.

Staff #106 no longer works in the home and therefore an interview was not conducted.

A review of resident #011's documentation notes indicated staff #106 had not completed any entry regarding their meeting with resident #011's SDM where prevention of falls and the incident from August 2018, had been discussed.

In an interview, staff #108 stated they had notified resident #011's SDM however a review of the documentation notes indicated this incident notification had not been documented nor any other conversation with the SDM or weekend nurse manager.

In an interview, staff #105 stated they had found out about this incident when they had overheard a conversation between staff #106 and staff #133 where staff #106 acknowledged that resident #011's SDM had been upset about not being informed of the actual events until three days later.

In an interview, staff #105 acknowledged it appeared that resident #011's SDM had not been notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a police reference check was conducted within six months before the staff member was hired.

In relation to non-compliances under the LTCHA, 2007, S.O. 2007, c.8, s.19 (1), employee and volunteer personnel files were reviewed.

A review of PSW #181's personnel file revealed that there was no valid police reference check. According to staff #182, staff #181 had submitted a police reference check (PRC) that was conducted more than six months prior to being hired. A review of the police reference check submitted by staff #181 indicated it had been completed on an identified date in December 2017. Staff #182 stated that the PSW had been asked to provide a PRC that was conducted within six months of hire but the PSW resigned after only two shifts. Staff #182 stated that staff #181 had completed orientation shifts on two identified date in November 2018.

Staff #105 and #133 acknowledged that the home failed to ensure that a PRC had been conducted within six months before staff #181 was hired. [s. 215. (2) (b)]

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : JOANNE ZAHUR (589), ARIEL JONES (566), NITAL SHETH (500), SUSAN SEMEREDY (501)

Inspection No. /
No de l'inspection : 2018_630589_0011

Log No. /
No de registre : 007753-17, 008984-17, 022298-17, 026610-17, 027593-17, 027880-17, 002200-18, 003340-18, 003749-18, 008962-18, 015921-18, 021047-18, 021914-18, 023011-18, 025086-18, 025643-18, 026189-18, 026453-18, 027248-18

Type of Inspection /
Genre d'inspection: Complaint

Report Date(s) /
Date(s) du Rapport : Dec 21, 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

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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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:

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

Ministère 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 : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_493652_0011, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Order / Ordre :

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

Specifically, the licensee shall:

a) prepare and implement a plan to ensure the emotional needs of resident #009 regarding any incidents of abuse are assessed and appropriate interventions for care are implemented,

b) ensure that all front line staff are trained on the licensee's prevention of abuse policy and understand the definitions that constitute verbal and emotional abuse,

c) ensure that specifically, PSW #179 is retrained on behaviour management, including caring for persons with dementia,

d) keep a documented record of the education material/components provided, staff that attended, the date(s) the education was provided and whom provided the education, and

e) maintain a documented record of each decision made pertaining to any residents' internal transfers including temporary room changes. Also, include the rationale for the decision made by the interdisciplinary team, staff involved in the decision and the date the decision was made.

Grounds / Motifs :

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

The following evidence related to resident #009 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC and according to this report, resident #009 had communicated on a social media platform with visitor/volunteer #208 who had been inappropriate towards them. The visitor first reported the conversation to staff #133, though only a small portion. Resident #009 later provided the entire conversation thread to staff #133 in which it indicated that visitor/volunteer #208 had been entirely inappropriate with them.

An interview between an inspector and staff #183 indicated that visitor/volunteer #208 had only been a volunteer for five months in 2017. According to staff #183, visitor/volunteer #208 did not work out as a volunteer for various reasons, including inappropriate interactions with residents. Visitor/volunteer #208 continued to visit the home as they were part of the Family Council and also had become a substitute decision-maker (SDM) for an identified resident residing in the LTCH.

An interview between an inspector and resident #009, indicated that during a social media platform interaction with visitor/volunteer #208 regarding resident #009's missing clothing, the messages became inappropriate. Resident #009 thought that resident #027 was wearing their missing clothing and had asked they be given back.

A review of the social media platform interaction provided by the LTCH indicated that visitor/volunteer #208 had used inappropriate language in their messages to resident #009 and spoke of resident #009's underlying health status. According to resident #009, after receiving the above mentioned message they went and informed the management of the LTCH.

A review of the CIS report indicated the police had advised resident #009 to stop all communication with visitor/volunteer #208 and if this person should try to contact the resident again, to inform the management of the home who will follow up with them. When speaking with an inspector, resident #009 stated the interaction had made them upset. Resident #009 further stated visitor/volunteer #208 uttered an inappropriate comment about them after seeing them coming

out of staff #133's office.

There was previous evidence that resident #009 and visitor/volunteer #208 had an encounter that was described as inappropriate in an email communication from staff #133. Review of this email communication provided by staff #183 to the inspector indicated that staff #133 had received a complaint from resident #009 that visitor/volunteer #208 had spoken inappropriately at them in the courtyard regarding designated smoking areas. Resident #009 further stated that visitor/volunteer #208 had gotten close to them during the above mentioned interaction.

In an interview, staff #133 stated that after the courtyard incident, the LTCH had sent visitor/volunteer #208 written communication regarding their inappropriate interactions with resident #009. Staff #133 acknowledged that visitor/volunteer #208's interactions with resident #009 had been inappropriate. [s. 19.] (589)

2. The following evidence related to resident #025 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC and according to this report, staff #100 had reported there was a commotion in front of the dining room and had observed staff #178 and resident #025 were in the vicinity with no other PSWs around. Staff #100 went to investigate what had happened and noticed resident #025 had an area of altered skin integrity. The police were informed of the incident.

Review of resident #025's medical record indicated the resident had been admitted to the LTCH with underlying health conditions and an impaired cognitive status. A review of an assessment indicated resident #025 exhibited responsive behaviours. Resident #025's plan of care indicated to staff interventions and strategies to be implemented when they were exhibiting responsive behaviours.

A review of resident #025's progress notes indicated that staff #100 had documented they had observed resident #025 exhibiting a responsive behaviours towards the staff. Staff #100 also observed that resident' #025's had an areas of altered skin integrity that they were unable to assess at that time due

responsive behaviours being exhibited by the resident.

In an interview, staff #100 verified the above noted progress note entry and stated they thought the incident was abuse and therefore reported it immediately to their manager.

A review of the home's investigation notes indicated staff #178 had admitted they had inappropriately touched resident #025 resulting in an area of altered skin integrity.

In an interview, staff #105 acknowledged the home had failed to protect resident #025 from abuse from staff #178. [s. 19.]

3. A CIS report was submitted to the MOHLTC regarding resident #023. The report further indicated that resident #023 had an area of altered skin integrity that was wrapped in gauze and that they had reported to staff #180 that staff #179 had caused them harm. A review of a complaint indicated there were concerns that after resident #023 had been admitted to the LTCH there were areas of altered skin integrity to identified areas.

In an interview, the complainant stated that shortly after resident #023 was admitted to the LTCH they noticed resident #023 had areas of altered skin integrity to identified areas and that their morale had plummeted.

A review of resident #023's health record indicated they had been admitted to the LTCH with an underlying health condition and associated impaired cognitive status. According to an assessment completed, resident #023 exhibited responsive behaviours. Progress notes indicated that on an identified date April 2017, resident #023 was observed about to use their mobility aid to strike their roommate therefore their mobility aid was removed and replaced with an alternate mobility aid.

A further review of progress notes indicated resident #023 was noted to have a dressing in place to an areas of altered skin integrity. According to a skin and wound note on the same day, staff #179 had reported that resident #023 had an area of altered skin integrity. This note further indicated that the altered skin integrity had occurred when a staff member had assisted resident #023 out of

another resident's room.

A review of the home's investigation notes regarding the above mentioned incident indicated staff #179 heard a resident in an identified room making noise and went to investigate. Staff #179 found resident #023 sitting on another resident's bed in the room with their mobility aid in front of them. Staff #179 pulled the call bell for assistance and staff #161 came to assist. Staff #179 stated resident #023 began to exhibit responsive behaviours and was swinging their mobility aid.The mobility aid was removed and the resident was escorted from the room. Staff #179 stated they immediately noticed the altered skin integrity and reported it to the charge nurse.

In an interview, staff #179 admitted their hand had come down upon resident #023's upper extremity during the above altercation. In an interview, staff #161 recalled staff #179 holding resident #023's upper extremity while they took the mobility aid away.

According to the home's investigation notes, staff #179 was given a discipline for the above mentioned incident.

In an interview, staff #105, acknowledged the home had failed to protect resident #023 from abuse by staff #179. [s. 19. (1)] (589)

3. A CIS report was submitted to the MOHLTC regarding resident #023. The report further indicated that resident #023 had an area of altered skin integrity that was wrapped in gauze and that they had reported to staff #180 that staff #179 had caused them harm. A review of a complaint indicated there were concerns that after resident #023 had been admitted to the LTCH there were areas of altered skin integrity to identified areas.

In an interview, the complainant stated that shortly after resident #023 was admitted to the LTCH they noticed resident #023 had areas of altered skin integrity to identified areas and that their morale had plummeted.

A review of resident #023's health record indicated they had been admitted to the LTCH with an underlying health condition and associated impaired cognitive status. According to an assessment completed, resident #023 exhibited

responsive behaviours. Documentation note entries indicated that on an identified date in April 2017, resident #023 was observed about to use their mobility aid to strike their roommate therefore their mobility aid was removed and replaced with an alternate mobility aid.

A further review of progress notes indicated resident #023 was noted to have a dressing in place to an area of altered skin integrity. According to a documentation note entry on the same day, staff #179 had reported that resident #023 had an area of altered skin integrity. This note further indicated that the altered skin integrity had occurred when a staff member had assisted resident #023 out of another resident's room.

A review of the home's investigation notes regarding the above mentioned incident indicated staff #179 heard a resident in an identified room making noise and went to investigate. Staff #179 found resident #023 sitting on another resident's bed in the room with their mobility aid in front of them. Staff #179 pulled the call bell for assistance and staff #161 came to assist. Staff #179 stated resident #023 began to exhibit responsive behaviours and was swinging their mobility aid.The mobility aid was removed and the resident was escorted from the room. Staff #179 stated they immediately noticed the altered skin integrity and reported it to the charge nurse.

In an interview, staff #179 admitted their hand had come down upon resident #023's upper extremity during the above altercation. In an interview, staff #161 recalled staff #179 holding resident #023's upper extremity while they took the mobility aid away.

According to the home's investigation notes, staff #179 was given a discipline for the above mentioned incident.

In an interview, staff #105, acknowledged the home had failed to protect resident #023 from abuse by staff #179. [s. 19. (1)]
(501)

4. A CIS report was submitted to the MOHLTC regarding resident #023. The report further indicated that resident #023 had an area of altered skin integrity that was wrapped in gauze and that they had reported to staff #180 that staff

#179 had caused them harm. A review of a complaint indicated there were concerns that after resident #023 had been admitted to the LTCH there were areas of altered skin integrity to identified areas.

In an interview, the complainant stated that shortly after resident #023 was admitted to the LTCH they noticed resident #023 had areas of altered skin integrity to identified areas and that their morale had plummeted.

A review of resident #023's health record indicated they had been admitted to the LTCH with an underlying health condition and associated impaired cognitive status. According to an assessment completed, resident #023 exhibited responsive behaviours. Progress notes indicated that on an identified date April 2017, resident #023 was observed about to use their mobility aid to strike their roommate therefore their mobility aid was removed and replaced with an alternate mobility aid.

A further review of progress notes indicated resident #023 was noted to have a dressing in place to an areas of altered skin integrity. According to a skin and wound note on the same day, staff #179 had reported that resident #023 had an area of altered skin integrity. This note further indicated that the altered skin integrity had occurred when a staff member had assisted resident #023 out of another resident's room.

A review of the home's investigation notes regarding the above mentioned incident indicated staff #179 heard a resident in an identified room making noise and went to investigate. Staff #179 found resident #023 sitting on another resident's bed in the room with their mobility aid in front of them. Staff #179 pulled the call bell for assistance and staff #161 came to assist. Staff #179 stated resident #023 began to exhibit responsive behaviours and was swinging their mobility aid.The mobility aid was removed and the resident was escorted from the room. Staff #179 stated they immediately noticed the altered skin integrity and reported it to the charge nurse.

In an interview, staff #179 admitted their hand had come down upon resident #023's upper extremity during the above altercation. In an interview, staff #161 recalled staff #179 holding resident #023's upper extremity while they took the mobility aid away.

According to the home's investigation notes, staff #179 was given a discipline for the above mentioned incident.

In an interview, staff #105, acknowledged the home had failed to protect resident #023 from abuse by staff #179. [s. 19. (1)]

4. On February 28, 2018, a compliance order (CO) #001, from inspection #2018_493652_0011 was made under LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) as follows:

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:

i) 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.

ii) to assess and provide residents with safe alternative tools for Activities of Daily Living (ADLs) i.e. metal grabbers, canes etc.

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

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

The compliance date was September 10, 2018.

During this inspection it was found that the home completed steps i, ii, and iv,

but failed to complete step iii.

A review of resident #018's progress notes indicated they had been transferred from the second to the fourth floor on an identified date in September 2018. Further review indicated resident #018 moved back to their room on the second floor on an identified date in October 2018.

In an interview, staff #156 stated the reason resident #018 was transferred to another room was because of a pest control issue the room needed to be treated. According to staff #156, this was a temporary transfer. Staff #156 was not aware that there was an interdisciplinary team approach to determine resident #018's suitability for the fourth floor as they assumed this had been completed by one of the DOCs and another nurse manager.

In an interview, staff #105 stated that an interdisciplinary approach was taken to determine resident #018's suitability to the fourth floor. Staff #105 indicated that the decision had not been documented to include the rationale for the decision, staff involved in the decision and the date. [s. 19. (1)]

The severity was determined to be a level two as there was minimal harm/risk or potential for actual harm/risk to residents. The scope was determined to be a pattern as it related to three of three residents inspected. The home had a level four compliance history as they had ongoing noncompliance with this section of the LTCHA:
-WN with CO issued July 13, 2018, closed with a link on November 1, 2018, under report #2018_626501_0010,
-WN with CO issued August 9, 2018, served under report #2018_493652_0011, order due date of September 10, 2018,
-WN with CO issued January 29, 2018, served under report #2017_420643_0024, closed with a link July 18, 2018,
-WN with CO issued October 17, 2017, served under report #2017_632502_0014, complied December 21, 2017, and
-WN with VPC served under report #2017_644507_0003, now closed. (501)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 02, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically, the licensee shall:

a) ensure all managers, and registered staff are provided with education on s. 24 (1) of the LTCHA related to the criteria based on reporting Certain Matters to the Director, and

b) the LTCH is to keep a record of the education material presented, date(s) the education was provided, staff that attended and who provided the education.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A complaint was received by the MOHLTC indicating that when resident #001's SDM had been visiting they heard resident #001 exhibiting a responsive

behaviour related to toileting. The PSW was overheard telling resident #001 they did not need to go. The SDM/complainant went to help resident #001 to the washroom and also reported the PSW had acted inappropriately towards resident #001. The incident was reported to the LTCH and it had been documented.

In an interview, resident #001's SDM stated as they exited from the elevator to the resident home area (RHA), they saw resident #001 asking staff for help to toilet, and the PSW saying, you are not going to use the washroom. While the SDM attempted to help the resident, a PSW stopped them as they could not help the resident. The SDM reported the incident to the nurse manager on the floor, and the manager indicated they would report it, and later on they said, that they had disciplined one of the staff members. The SDM indicated that it is the resident's basic right to use the bathroom.

A review of resident #001's current written plan of care indicated that staff are to toilet resident #001 twice a shift and when needed to ensure the resident is dry and clean. A review of the resident's clinical record and progress notes did not indicate documentation about the above mentioned incident.

In an interview, staff #103 stated that resident #001's SDM had raised a concern about continence care, and that the staff had reported they had just provided care to resident #001 and could not do it again. There was no reporting completed for the incident.

In an interview, staff #105 indicated that any alleged abuse and neglect incidents should be reported to the MOHLTC immediately and investigated. [s. 24. (1)]

A review of resident #001's current written plan of care indicated that staff are to toilet resident #001 twice a shift and when needed to ensure the resident is dry and clean. A review of the resident's clinical record and progress notes did not indicate documentation about the above mentioned incident.

In an interview, NM #103 stated that resident #001's SDM had raised a concern about continence care, and that the staff had reported they had just provided care to resident #001 and could not do it again. There was no reporting completed for the incident.

In an interview, staff #105 indicated that any alleged abuse and neglect incidents should be reported to the MOHLTC immediately and investigated. (500)

2. A complaint was received by the MOHLTC related to a fall incident that had occurred in the shower room involving resident #007. The complainant stated resident #007 had been seated in a bathing assistive aid and when staff #166 was moving the bathing assistive aid over the floor lip into the shower area it tipped and both resident #007 and staff #166 fell onto the floor. The complainant further stated resident #007 had voiced to them that staff usually use an alternate bathing assistve aid and that two staff are usually present to move it over the floor lip safely however on this day, staff #166 was alone. Complainant stated they were concerned for any emotional trauma experienced by resident #007 related to this incident.

A review of the most recent health record under the activities of daily living (ADL) self care performance focus indicated that two staff are to transfer the resident to and from the shower stall with the use of the bathing assistive aid for safety.

In a conversation with resident #007, they remembered the fall incident in the shower had occurred but could not recall if an alternate bathing asisitive aid had been used. Resident #007 further stated they had not been injured in this incident and had no other subsequent injuries noted in the days afterwards.

In an interview, staff #166 acknowledged they had completed the transfer unassisted resulting in the fall and had been informed after the incident by staff #105, that the care plan indicated two staff are to be present when a bathing assistive aid is in use.

A review of the MOHLTC's critical incident system (CIS) on-line reporting and an interview with staff #105 indicated that a CIS report had not been submitted related to the above mentioned fall incident that involved improper care of resident #007 by staff #166.

In an interview, staff #105 acknowledged the home had failed to report this incident to the Director related to improper care of resident #007 that resulted in

a fall incident and risk of harm to them. [s. 24. (1)] (589)

3. The following evidence related to resident #009 was found under inspection report #2018_626501_0021.

A CIS report was submitted to the MOHLTC regarding visitor/volunteer verbal and emotional abuse towards resident #009.

A review of an email communication provided by staff #183 to the inspector indicated staff #133 had received a complaint from resident #009 that visitor/volunteer #208 had spoken inappropriately to them in the courtyard regarding designated smoking areas. During an interview, resident #009 stated visitor/volunteer #208 had gotten close to them and had spoken inappropriately.

In an interview, staff #133 stated that after the incident in the courtyard, the home had sent visitor/volunteer #208 written communication regarding. Staff #133 acknowledged that the inappropriate conversation in the courtyard was abusive and they had failed to immediately report the incident to the Director. [s. 24. (1)]

The severity was determined to be a level two indicating minimum harm or potential for actual harm. The scope was determined to be a level two indicating a pattern and the compliance history was determined to be a level three indicating one or more related non-compliance in the last 36 months, therefore a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 02, 2019

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

Ministère 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 : 003

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

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 O. Reg. 79/10, r. 36.

Specifically, the licensee shall:

a) ensure PSWs #154, #162, #166 and all other PSWs are provided education on safe transferring, positioning devices or techniques and on strategies to request assistance without leaving the resident's side when providing care and assistance,

b) ensure PSWs #154, #162, #166 and all other PSWs are provided education on the safe use of all mechanical lifts,

c) keep a documented record of the education sessions provided that includes the material covered, date(s) of when the education was provided, staff that attended and who provided the education sessions, and

d) develop and implement a documented auditing system that consists of audits of staff #154, #162, #166 and all other direct care staff providing care to ensure safe transferring and positioning devices or techniques are being used when assisting residents, that includes the date of the audit, who completed the audit, the outcome of the audit and any actions taken as a result of the audit.

Grounds / Motifs :

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

Upon conducting observations related to temperatures in the home, the

inspector observed resident #016 unattended in a bathroom with a mobility transfer aid attached.

The inspector observed resident #016 alone in the bathroom seated on the toilet with a mobility transfer aid in place which was still attached to the mechanical lift. There were no staff members in sight however resident #016 indicated to the inspector they knew where the call bell was located. Staff #154 then entered the bathroom followed shortly by staff #155.

A review of resident #016's current plan of care indicated they needed extensive assistance from two staff for toileting and to assist with transferring to and from the bathroom with a mechanical lift.

In an interview, staff #154 stated they had only left resident #016 for a short period of time in order to call for another PSW to help with transferring. Staff #154 admitted they should not have left the resident alone attached to the mechanical lift.

In further interviews, staff #153, #152 and #130 stated that it is not safe for PSWs to leave residents unattended when attached to a mechanical lift. In an interview, staff #156 confirmed that staff #154 did not use safe positioning techniques when assisting resident #016. [s. 36.]
(501)

2. A CIS report was submitted to the MOHLTC indicating resident #017 was found with altered skin integrity to identified body parts on an identified date in September 2018.

A review of the resident #017's plan of care indicated they required one staff member to provide total assistance with care needs and the use of a mobility transfer aid for transfers.

A review of the home's investigation into what happened indicated that staff #162 had transferred resident #017 without the assistance of another staff member. In an interview, staff #162 stated they were aware that they should have had another staff member assist when transferring resident #017. Staff #162 stated they did not ask another staff member to help because everyone

was busy. In an interview, staff #164 stated they had helped staff #162 transfer resident #017 from the bed to a bathing aid but had not helped with transferring the resident back to bed.

A review of the home's policy #VII-G-20.20(a) titled: Resident Transfer and Lift Procedures last revised December 2017, indicated that two caregivers must be present during the lifting/transferring procedure when using a mechanical lift. Policy #VII-G-20.20(l) titled: Mechanical Lifting & Sling Safety Protocol states that when a mechanical lift is utilized, two staff members are required to perform the function. At no time is it permissible for only one staff to operate a mechanical lift.

In an interview, staff #105 confirmed staff #162 had not used safe transferring techniques when assisting resident #017 back to bed. [s. 36.]mechanical lift. Policy #VII-G-20.20(l) titled: Mechanical Lifting & Sling Safety Protocol states that when a mechanical lift is utilized, two staff members are required to perform the function. At no time is it permissible for only one staff to operate a mechanical lift.

In an interview, staff #105 confirmed PSW #162 had not used safe transferring techniques when assisting resident #017 back to bed on September 24, 2018. (501)

3. A complaint was received by the MOHLTC related to a fall incident that had occurred in the shower room involving resident #007. The complainant stated resident #007 had been seated in a bathing assistive aid and that when staff #166 was moving the bathing assistive aid over the floor lip into the shower area it tipped and both resident #007 and staff #166 falling to the floor. The complainant further stated resident #007 had voiced to them that staff usually use an alternate bathing assistive aid and that two staff are usually present to move the chair over the floor lip safely, but on this day, staff #166 was alone. The complainant stated they were concerned for any emotional trauma experienced by resident #007 related to this incident.

A review of the most recent health record under the ADL self care performance focus indicated that two staff are to transfer to and from the shower stall with the use of the bathing assistive aid for safety.

In a conversation with resident #007, they remembered the fall incident had occurred in the shower but could not recall if the type of bathing assistive aid that had been used. Resident #007 further stated they had not been injured in this incident and had no other subsequent injuries noted in the days afterwards.

In an interview, staff #166 acknowledged they had completed the transfer unassisted and therefore the transfer had been unsafe. Staff #166 further stated staff #105 had provided re-instruction, informing them the transfer required two staff for safety as identified in resident #007's plan of care.

In an interview, staff #167 stated it was safe to say that an improper transfer had occurred with resident #007 as staff #166 had not provided care as per the plan of care as they had completed the transfer unassisted by a co-worker and as a result had been pushing the shower chair over the floor lip resulting in a fall incident.

In an interview, staff #105 acknowledged that by failing to provide care as per the plan of care, staff #166 had failed to use safe transferring and positioning devices or techniques when assisting resident #007. [s. 36.]

The severity was determined to be a level two indicating minimum harm or potential for actual harm. The scope was determined to be a level two indicating a pattern and the compliance history was determined to be a level four indicating despite MOH action (VPC, order, DR), non-compliance continues with original area of non-compliance:
-Inspection #2017_324535_0023, served a written notice with compliance order and Director's Referral were served,
-Inspection #2017_324535_0014, served a written notice with compliance order and Director's Referral was closed with a link,
-Inspection #2017_644507_0003, served a written notice with compliance order and Director's Referral was closed with a link, and
-Inspection #2016_353589_0016, served a written notice with compliance order closed with a link. (589)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 02, 2019

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

Ministère 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 90 (2) (g).

Specifically, the licensee shall:

a) ensure all registered staff and front line staff are provided education on the home's policy #VII-H-10.70 titled: Water Temperature Monitoring and when temperatures are below 40 degrees Celsius or exceed 49 degrees, what steps to take and the interventions to be implemented when water temperatures are not within acceptable guidelines,

b) develop and implement audits to ensure that the temperature of the hot water serving all bathtubs, showers, and sinks used by residents will be monitored daily once per shift in random locations where residents have access to hot water. The audit should include who completed the audit, where the audit was completed, the outcome of the audit, any actions required and the date the audit was completed, and

c) develop and implement a reporting system that identifies who is to specifically be notified when water temperatures are not within acceptable guidelines in the absence of the Director of Environmental Services.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were implemented to ensure that the temperature of the water serving all showers used by residents was 49 degrees Celsius or less.

A CIS report was submitted to the MOHLTC that indicated resident #017 was found with altered skin integrity to identified body areas which required a transfer to hospital for further assessment.

In an interview, resident #017's SDM stated they were very upset that the home first told them the resident had only redness, then were told the resident was being sent to the hospital for further assessment. The SDM was told that the altered skin integrity happened during bathing when the water was not within normal ranges.

A review of resident #017's progress notes indicated the assigned PSW

reported to the RN that they noted altered skin integrity to an identified body area. The RN went to assess resident #017 and noted areas of altered skin integrity. Resident #017 exhibited discomfort while being moved during the assessment. The PSW told the RN the altered skin integrity was noted during their shower. The RN called the physician and received an order to send resident #017 to hospital. A review of a progress note on an identified date in September 2018, indicated the hospital told the LTCH that resident #017 had sustained multiple areas of altered skin integrity.

In an interview, staff #162 stated they had given resident #017 a shower and according to staff #162, they had checked the water temperature from the hand held shower head prior to beginning the shower and the temperature had been acceptable. Staff #162 first rinsed the resident and then hung the shower head on a shower bar while washing resident #017. Staff #162 did not check the temperature again as the water was still running and proceeded to rinse the resident. Staff #162 noticed resident #017 exhibit a responsive behaviour so they moved the water hose away from the resident and tested the water which was too hot and proceeded to reset the temperature and finished rinsing the resident. Staff #162 stated that they noticed the altered skin integrity when drying the resident. Staff #162 also indicated that fluctuating water temperatures had been an ongoing issue and was aware that it had been reported in the LTCH's electronic maintenance reporting system and to an identified floor manager who was also the LTCH's C-DOC.

In an interview, staff #163 stated the LTCH had been having issues with the water temperature on an identified side of the building for quite some time. Staff #163 further stated they did not think the LTCH had taken any action to deal with the water temperature issue until the incident with resident #017 happened. In an interview, staff #164 stated the water sometimes would get hot then goes back cold which had been a problem for a while.

In an interview, resident #018 stated that during their showers the water temperature would go back and forth and the staff have to make adjustments. In an interview, resident #019 stated that the water temperature would get hot then cold, was always changing and the staff were always checking.

A review of Maintenance Care Communication from the floors indicated that

water temperatures on an identified side of the building had been an ongoing issue since June 14, 2018 as follows:
•June 14, 2018: Not enough hot water, sixth floor, north side shower room,
•June 15, 2018: Only cold water in north shower room, sixth floor,
•June 19, 2018: Water won't stay warm during shower. Five minutes it is warm then turns cold even when we turn the knob to full hot. Happening morning and evening showers. Ongoing. PSWs unable to give showers as it turns cold during showers. 6th floor north side shower room. Submitted by Nurse Manager/DOC #105,
•July 12, 2018: No hot water in north side shower room on sixth floor,
•July 19, 2018: North side shower we are only getting cold water third floor,
•July 22, 2018: North side shower room we do not have hot water only at the face basin, none in shower, third floor,
•July 30, 2018: Shower temperature is not hot enough north shower room on second floor,
•August 1, 2018: The water is not getting hot enough for residents to take shower. It's cold. North side shower, fifth floor,
•August 6, 2018: Daughter complained that when water is turned on (cold or hot) it's either really cold or really hot and that it is never just warm, washroom sink on third floor (room 307 on the north side),
•August 21, 2018: Shower room water cold no hot water, sixth floor, and
•August 27, 2018: Shower room water cold no hot water, sixth floor.

A review of the home's policy #VII-H-10.70 titled: Water Temperature Monitoring last revised July 2015, indicated that the temperature of the hot water serving all bathtubs, showers, and sinks used by residents will be maintained at a temperature not below 40 degrees Celsius and will not exceed 49 degrees Celsius and will be monitored daily once per shift in random locations where residents have access to hot water.

In an interview, staff #135 who works two days a week at the home since an identified date in July 2018, stated they were aware of issues with the water temperatures and stated that the maintenance supervisor would often go onto the roof to adjust the mixing valve. According to staff #135, maintenance takes temperatures in all shower units once a day. A review of the daily maintenance checklist from September 16, 2018, to September 22, 2018, indicated the water temperature in the 6th floor shower room was 48 degrees Celsius every day. All

other floors had water temperatures within the range of 40 to 49 degrees Celsius. There were no daily maintenance checklists provided for September 23, 2018.

In an interview staff #105 admitted that nursing staff had not been monitoring water temperatures each shift in random RHAs. Staff #105 stated that nursing staff were not using the form titled Resident Care Area Water Temperatures and were using the 24 hour shift report to document water temperature readings and were doing so only intermittently. According to staff #105, nursing were not monitoring water temperatures according to the home's policy.

In an interview, staff #133 stated that a staff member had brought to their attention sometime in late August 2018, that staff had been reporting no hot water on the north side of the building and that nothing was being done about it. According to staff #133, a plumbing contractor was brought in August 24 and 25, 2018, and the issue had been resolved by diverting water from the tubs. However, the LTCH learned after the incident with resident #017, that there was a problem with the mixing valve which needed to be replaced. Staff #133 acknowledged that because they do not have a dedicated manager of the maintenance department, there was no one overseeing the maintenance requests on their electronic system known as Maintenance Care. Staff #133 also acknowledged that the home had not been monitoring water temperatures daily once per shift in random locations where residents have access to hot water. [s. 90. (2) (g)]

The severity was determined to be a level three indicating actual harm/risk to resident #017. The scope was determined to be a level one as was isolated to resident #017 and the compliance history was determined to be a level two indicating one or more unrelated non-compliances in the last 36 months. Due to actual harm to resident #017, a compliance order is warranted. (501)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 02, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 21st day of December, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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