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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 08, 2019	2019_324535_0003 (A2)	030057-18, 031988-18, 001767-19	Critical Incident System

Licensee/Titulaire de permis

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

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

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

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

Amended by VERON ASH (535) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension, granted and compliance due date for all orders will be June 10, 2019.

Issued on this 8 th day of April, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by VERON ASH (535) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 21, 22, 23, 24, 30, 31, February 4, 5, 6, 7, 8, 13, 14, 2019.

The following intakes were completed: Log #s :031988-18 (related to physical abuse); 001767-19 (related to physical abuse); 030057-18 (related to unknown injury).

Evidence in this report will be used to support a compliance order issued in inspection report #2018_630589_0011, dated December 21, 2018, due date April 26, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOCs (ADOCs), Environmental Manager, Maintenance Supervisor, Resident Assessment Instrument (RAI) Coordinator, Wound Care/Rehabilitation Nurse, BSO Nurse, Scheduling Clerk, registered staff RN/ RPN; personal support worker (PSW), Substitute Decision Makers (SDMs) and residents.

During the course of the inspection, the inspector made observations related to the home's care processes, staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
12 WN(s)
2 VPC(s)
6 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident report related to resident #003's responsive behaviors which caused injuries to residents and staff in the home.

Record review of the progress notes indicated that resident #003 was involved in multiple episodes of resident-to-resident physical altercations over a few identified months. The inspector reviewed the resident's documented responsive behaviors over an identified period during those months because another resident in the home reported a previous altercation which occurred on an earlier identified date.

During an interview, registered staff RPN #115 stated the resident usually displayed responsive behaviors; however over the past months, the resident displaying more behaviors and does not recall the incidences when asked. According to PSW #111, the resident would display a behavior if they were upset. The PSW also verified that this information was not identified and documented in the resident's plan of care for all to be aware.

During an interview, the support team RPN verified that the resident should have been reassessed by the external support team with the intent to receive an evaluation and referral to another facility for assessment and treatment.

During an interview, ADOC #102 stated that they were not aware of the number of altercations involving resident #003. The ADOC verified that resident #003 should have been reassessed by the external support team. Therefore, the home failed to ensure procedures and interventions were implemented to assist residents and staff who were at risk of harm as a result of resident #003's displayed behaviors. [s. 55. (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The MOHLTC received a critical incident report related to resident #002's responsive behavior which caused an injury to resident #001.

Record review of the progress notes indicated over an identified period of months after resident #002's admission to the home, they were involved in multiple altercations with resident #001.

During separate interviews, RPN #107 and PSW #123 verified that they both had concerns related to resident #002's displayed responsive behavior on the unit.

During an interview, support team RPN #105 verified that they were not aware of some behavior incidents on identified dates since they did not receive an electronic referral from the registered staff working on the unit. The support team RPN also verified that although they were aware of the other incidences, they did not consult with the external support team for further assessment and recommended treatments. The support team RPN verified that they sent a referral to the support team after the last incident which resulted in an injury to resident #001.

During an interview, ADOC #102 verified that they were not aware of resident #002's displayed behaviors, nor were they aware of the staff concerns regarding the same. Furthermore, the ADOC verified that the registered staff should have submitted a referral to the internal support team for assessment after each incident.. As well, after the second incident occurred, if beyond their scope, the support team RPN should have referred the resident to the external support team for further assessment and recommended treatment. The ADOC agreed that there was no collaboration between members of the interdisciplinary teams in order to enure that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The Ministry of Health (MOH) received a critical incident report related to resident #003's behaviors.

Record review of the progress notes indicated that resident #003 was involved in altercations with other residents in the home on multiple identified dates.

During an interview, the resident's primary PSW #111 stated that the resident wants to be treated with respect. The PSW believed that this information could be an important identified triggers related to the resident's relationship toward others. The PSW also noted that this information should be identified and documented in the resident's plan of care so that everyone could become aware. After reviewing the resident's electronic kardex, the PSW verified that the resident's identified

trigger was not included in the resident's Kardex for everyone to be able to access. Furthermore, PSW #111 stated that PSWs were the key to providing residents' care; however the home does not speak with them when developing the residents' plan of care. They reiterated that the team should have a discussion with primary PSWs about their residents because they work with those residents and knew them best.

During an interview, support team RPN #105 verified that they were not aware of some of the resident #003's altercations with others. However, during interviews with staff on the unit, they stated that although they did not consistently complete an electronic referral and send to the support staff, the support team RPN was notified of the altercations by other means.

During an interview, ADOC # 102 stated that they were not aware of the number of altercations involving resident #003. The ADOC verified that resident #003 should have been assessed after each incident, and their triggers identified by the team so that strategies could be introduced to mitigate further incidences. In addition, the ADOC stated that the resident should have been referred to the external support team for reassessment and recommendations. Therefore, the home failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

3. The MOHLTC received a critical incident report related to resident #007's incident of unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling out for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support because the resident who was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury on an identified part of the body.

During an interview, ADOC #113, who was also the Fall Prevention Program Lead verified that the resident should have had fall prevention strategies in place at the time of their admission into the home, since they were assessed to be at high risk

for falls. The ADOC also verified that they were not aware of the family's request to have a specific device applied to the resident's bed, which would have been provided after an assessment and consent by the family. The ADOC acknowledged that the registered staff should have discussed the resident's needs and the SDM's request with the Falls Prevention Program Lead to ensure collaboration of the resident's care and prevent resident #007 from getting out of bed again, thereby preventing the injury. [s. 6. (4) (a)]

4. The MOHLTC received a critical incident report related to resident #007 incident of unknown injury.

Record review indicated resident #007 was admitted to the home on and received an assessment using the home's annual MDS assessment tool.

Record review of the progress notes, medication administration records, and intake records indicated and staff interviews verified that resident #007 was usually well behaved at times; however, the resident often displays a responsive behavior. The resident's written care plan included some related information; however, there was no indication the resident was referred to the home's support team for appropriate interventions.

During an interview, support team RPN #105 verified that the resident was not referred to the support team. Furthermore, the RPN stated that residents who refused care and treatment should be referred to the support team for supportive interventions. [s. 6. (4) (a)]

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

The MOHLTC received a critical incident report related to an incident with resident #002 and resident #001.

Record review of the progress notes indicated over a period of four months since resident #002's admission, the two were involved in three altercations.

Record review indicated and staff interview verified that at the time of notification of the second incident, resident #001's SDM requested a follow up plan to ensure the resident would be safe with no further incidents. However, on another

identified date when the third incident occurred, resident #001 sustained an injury and was transferred to the acute care hospital.

During an interview, ADOC #102 verified that they were aware that resident #001's SDM had expressed concerns related to resident #002. However, they went on vacation from during a specified time period and returned on the day of next incident. ADOC #102 verified that they do not believe the family was contacted with a plan to be implemented to protect resident #001; and they had not spoken with the family regarding the same prior to leaving for vacation. Therefore, the home failed to ensure the SDM was provided the opportunity to participate fully in the development and implementation of resident #001 plan of care. [s. 6. (5)]

6. The MOHLTC received a critical incident report related to resident #007's sustaining an unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury to an identified part of the body.

During an interview, the resident's SDM stated that they believe the resident may have tried to get up from the bed and possibly struck the identified body part against something. According to the SDM, they requested a specific safety device for the resident after the resident's previous incident when they sustained an injured; however they stated the home did not provide the safety device requested. The SDM verified that they were still waiting to hear back from the home about their request which would have prevented this recent incident and prevented further injury.

During an interviews, the ADOC, who was also the Fall Prevention Program Lead verified that the resident should have had Fall Prevention strategies in place at the time of their admission into the home, since they were assessed to be high risk for falls. The ADOC acknowledged that the home failed to ensure the resident's SDM was provided the opportunity to participate fully in the

development and implementation of the plan of care by not respecting and granting their request which would have prevented further injury. [s. 6. (5)]

Additional Required Actions:

CO # - 002, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 002,006

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately

investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

The MOHLTC received a critical incident report related to resident #004 sustained injury which required first aid treatment.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, PSW #129 observed resident #003 asleep in another resident's room. The PSW redirected the resident to their own room. Resident #003 became upset and had an altercation with two separate residents as they were leaving the room. Resident #004 was one of those residents who sustained an injury to an identified body part. Resident #004 was treated with first aid. Resident #003 was redirected to their room with close monitoring by a PSW.

During an interview, ADOC #102 verified that the incident occurred and that there was no investigative notes available related to the incident. The ADOC also indicated that the altercation was considered abuse of resident #004 by resident #003. [s. 23. (1) (a)]

2. The MOHLTC received a critical incident report related to resident #005 sustained an injury which required first aid treatment and clinical monitoring.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, PSW #129 observed resident #003 asleep in another resident's room. The PSW redirected the resident to their own room. Resident #003 became upset and had an altercation with two separate residents as they were leaving the room. Resident #005 was one of those residents, who sustained an injury to an identified body part. Resident #005 was treated with first aid and close monitoring. Resident #003 was redirected to their room with close monitoring by a PSW.

During an interview, ADOC #102 verified that the incident occurred and that there was no investigative notes available related to the recent incident. The ADOC also indicated that the altercation was considered abuse of resident #005 by resident #003. [s. 23. (1) (a)]

3. The MOHLTC received a critical incident report related to resident #007 sustaining an unknown injury.

Record review indicated resident #007 was admitted to the home and was assessed using the home's annual MDS assessment tool.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury to an identified part of the body. RN #132 was unavailable for an interview during the period of this inspection.

During separate interviews, the Director of Care and ADOC #113 verified that an investigation was not completed related to the incident of unknown injury; and both agreed that an investigation should have been completed. [s. 23. (1) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 003

WN #4: 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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The MOHLTC received a critical incident report related to resident #002's responsive behaviors which caused an injury to resident #001.

Record review indicated and staff interview verified that on an identified date and time, resident #002 and resident #001 had an altercation in their room which resulted in an injury with altered skin integrity to resident #001 identified body part. The resident was transferred to hospital; and returned to the home on an identified date with a specified diagnosis.

Record review indicated that on an identified date, the registered staff documented in the electronic progress note that the resident had an altered skin integrity; however the staff did not complete an electronic assessment which was required; and did not document the altered skin integrity in the resident's electronic treatment assessment record (TAR) for monitoring.

Record review also indicated that on an identified date, registered staff #107

completed the electronic assessment; however there was no further weekly assessment completed for the resident related to the altered skin integrity as verified by the Skin and Wound Care Lead. [s. 50. (2) (b) (iv)]

2. The MOHLTC received a critical incident report related to resident #007's unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury with altered skin integrity to an identified part of the body.

Record review also indicated that PSWs documented the altered skin integrity during their shifts; however registered staff did not completed the electronic assessment, nor did they complete assessments related to the resident's altered skin integrity as verified by the Skin and Wound Care Lead.

During an interview, Skin and Wound Care Lead #106 verified an assessment should have been completed by the registered staff on the same identified date as the incident occurred. Furthermore, the Skin and Wound Care lead verified the following:
-the home switched to a new electronic documentation system; and the new system does not auto-generate scheduled assessments to alert registered staff to complete altered skin integrity assessments;
-it was currently difficult to track the treatment of some forms of altered skin integrity in the home; and,
-altered skin integrity should be documented by registered staff using the progress notes and appropriate assessment tools; however, although training was provided, registered staff was not consistently completing both documents.
Therefore, the home failed to ensure that residents #002 and #007's altered skin integrity were reassessed at least weekly by a member of the registered nursing staff as clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 004

WN #5: 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 has failed to ensure steps were taken to minimize the risk of altercation and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

The MOHLTC received a critical incident report related to resident #002's responsive behaviors.

Record review of the progress notes indicated that over a period of identified months since resident #002's admission to the home, they were involved in three resident-to-resident altercations involving resident #001.

During an interview, support team RPN #105 stated the team had identified that resident #002 had an identified responsive behavior. The RPN also verified that after the first two incidences, the resident was assessed; however the support team RPN did not implement change in interventions nor consulted with the external support team for further assessment because the resident was not injured; and both residents resettled with no further incident. After the final incident on an identified date, the external support team was consulted and interventions were put in place, and both residents were separated.

During an interview, ADOC #102 stated that if a resident's responsive behaviors were beyond the scope of the support team RPN, they should have followed the home's Protocol and consulted with the external support team team for further assessment and recommended treatment. The ADOC verified that further assessment and interventions should have being implemented prior to the third incident. Therefore, the home failed to ensure steps were taken to minimize the risk of altercation and potentially harmful interactions between residents. [s. 54. (a)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended: CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident was assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The MOHLTC received a critical incident report related to resident #007 incidence of unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling out for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury to an identified part of the body.

The inspector reviewed the previous incident which occurred on an identified date, since both the current incident of the resident getting out of bed and sustaining an injury; and the previous incident were considered related as voiced by resident #007's SDM. A review of the assessments and progress notes indicated that on an identified date, resident #007 experienced a similar incident on an identified date and time. A PSW found resident #007 had fallen. The resident was assessed and sent to the hospital for further assessment; and they returned with a diagnosed injury. The home's assessment records indicated that the required assessment was not completed by the registered staff related to the incident. Registered staff RN #132 was not available for an interview during the inspection period.

During an interview, the resident's SDM stated that they believe the resident may have tried to get up from the bed and possibly struck the identified body part against something. According to the SDM, they requested the use of a safety devices since the resident's last incident on a previously identified date; however the home did not provide the safety device; and the SDM stated they were still waiting to hear about their request.

During an interview, ADOC #113 and DOC #101 verified that the required assessment was not completed by the registered staff related to the identified incident. Both verified that the electronic assessment should have been completed. Therefore, the home failed to ensure that resident #007 received a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioral triggers were identified for the resident demonstrating responsive behaviors, where possible.

The MOHLTC received a critical incident report related to resident #003's responsive behaviors which caused two residents to sustain injuries.

Record review of the progress notes indicated that resident #003 was involved in multiple resident-to-resident altercations over identified months. The inspector reviewed the resident's behaviors after a resident reported a previous altercation which occurred on another identified date. The progress notes indicated that the resident was involved in altercations on multiple identified dates.

During an interview, registered staff RPN #115 stated the resident usually displayed responsive behaviors; however over the past months, their behaviors

were more frequent; and they usually do not recall the incidences.

During an interview, the primary PSW #111 described the resident's usual mannerism. The PSW also stated they believed those mannerisms could be the trigger for the resident's behavior, which should be identified and documented in the resident's plan of care so that everyone could be aware. However, according to the PSW, the home does not include PSWs in the development of residents' care plan; and they verified this important information was not included in the resident's Kardex by reviewing the POC.

During an interview, support team RPN #105 verified that the resident's responsive behavior trigger was identified regarding their past behaviors; however the behavior trigger was not identified related to their current responsive behaviors.

During an interview, ADOC # 102 stated that they were not aware of the number of altercations involving resident #003. ADOC #102 verified that resident #003 should have been assessed after each behavior incident and behavioral triggers identified by the team or the resident should have been referred to the external support team for reassessment and recommendations to prevention further display of responsive behaviors towards resident and staff. [s. 53. (4) (a)]

2. The licensee has failed to ensure actions were taken to meet the needs of the resident with responsive behaviors including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

The MOHLTC received a critical incident report related to resident #002's responsive behaviors.

Record review indicated and staff interview verified that on an identified date, resident #002 and resident #001 had an altercation. When the registered nurse arrived in the room, they found resident #001 had sustained an injury. Resident #001 was transferred to hospital; and returned to the home with a diagnosed injury.

A review of the resident's electronic documentation indicated that the resident was to be closely observed during an identified period; however the resident's electronic record was left blank during that period, except for one entry on an identified date and time.

During an interview, the support team RPN #105 verified that once the observation period was assigned in POC, and PSWs were to complete the monitoring record during their shift. The support team RPN reviewed the specific monitoring records and verified that PSWs did not complete the monitoring electronically as was required; and paper documents were not located for that same period. Therefore, the home failed to ensure actions were taken to meet the needs of the resident with responsive behaviors including documentation of the resident's responses to the interventions. [s. 53. (4) (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 -to ensure that the behavioral triggers are identified for the resident demonstrating responsive behaviors, where possible; and,
-to ensure actions are taken to meet the needs of the resident with responsive behaviors including assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #8: 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 :

(A1)
1. The licensee has failed to ensure resident #001 was protected from abuse by

anyone.

Ontario Regulations 79/10, s. 2 (1) (c) indicated physical abuse means the use of physical force by a resident which causes physical injury to another resident.

The Ministry of Health and Long Term Care (MOHLTC) received an identified critical incident, on an identified date, related to resident #002's responsive behavior which caused resident #001 to sustain an injury for which they were transferred to hospital for assessment and treatment.

Record review indicated resident #001 was admitted to the home and was assessed using the home's quarterly MDS assessment tool; as was resident #002.

A review of the progress notes indicated a number of resident-to-resident altercations between both residents; with resident #001 sustaining an injury after the last identified incident.

During an interview, the support team RPN #105 stated they were aware of the last identified incident; and that they had made some suggestions for change; however, there were no actions taken by the team to implement those suggestions.

During separate interviews, RPN #107 and PSW #123 stated that they had concerns related to both residents. And, RPN #107 verified that they had informed management in a previous meeting of their concerns. RPN #107 verified that the incident which occurred on December 4, 2018, fits the definition of physical abuse.

During an interview, ADOC #102 acknowledged that the home failed to protect resident #001 from abuse by resident #002; and that there should have been interventions put in place to prevent further altercations between both residents.
THIS EVIDENCE WILL BE USED TO SUPPORT INSPECTION #2018_630589_0011 DATED DECEMBER 21, 2018 - DUE DATE APRIL 2, 2019. [s. 19. (1)]

2. The MOHLTC received an identified critical incident, on an identified date, related to resident #003's responsive behaviors causing resident #005 to sustain an injury which required first aid treatment and clinical monitoring.

Record review indicated resident #003 was admitted to the home; and was assessed using the home's quarterly MDS assessment tool. as was resident #005.

Record review of the progress notes and the critical incident report indicated the following that an incident occurred on an identified date and time. On that date and time, PSW #129 observed resident #003 sleeping in another resident's room. The PSW redirected the resident to their own room; and resident #003 became upset and subsequently engaged in an altercation with resident #005. Resident #005 sustained an injury to an identified body part, and was treated with first aid and special monitoring. Resident #003 was redirected to their room and monitored with a scheduled one to one PSW.

During an interview, resident #005 verified that the incident occurred as described above; and informed the inspector that this was their second altercation with that same resident. Resident #005 stated that after the recent identified incident, they sustained an injury and required close monitoring. The resident also recalled and described the first incident which also involved resident #003.

During an interview, registered staff RPN #115 verified that the information to keep resident #003 and resident #005's separated was not included in the resident's written care plan.

During an interview, support team RPN #105 stated that they were not aware of the first incident since they did not receive an electronic referral from the registered staff after they assessed the resident. The support team RPN verified that resident #003 was referred to the external support team for follow up and intervention after the last identified incident.

During an interview, ADOC #102 verified that they learned about the first incident from resident #003's family member during a discussion after the last incident on an identified date; and that they were currently conducting an investigation related to both incidences since the family member expressed concerns regarding the repeated incident between both residents. The ADOC also verified there were no investigative notes available related to both incidents.
THIS EVIDENCE WILL BE USED TO SUPPORT INSPECTION #2018_630589_0011 DATED DECEMBER 21, 2018 - DUE DATE APRIL 2, 2019. [s. 19. (1)]

3. The MOHLTC received an identified critical incident, on an identified date, related to resident #003's responsive behaviors which caused resident #004 to sustain an injury which required first aid treatment.

Record review indicated resident #004 was admitted to the home and was also assessed using the quarterly MDS assessment tool.

Record review of the progress notes and the critical incident report indicated the following that an incident occurred on an identified date and time. On that date and time, PSW #129 observed resident #003 sleeping in another resident's room. The PSW redirected the resident to their own room; and resident #003 became upset and subsequently engaged in an altercation with resident #004. Resident #004 sustained an injury to an identified body part, and was treated with first aid. Resident #003 was redirected to their room and monitored with a scheduled one to one PSW.

During an interview, support team RPN #105 verified that resident #003 was referred to the external support team for reassessment and recommended interventions after the most recent incident.

During an interview, ADOC #102 verified that there were no investigative notes available related to the identified date, and that the altercation was considered abuse of resident #004 by resident #003.
THIS EVIDENCE WILL BE USED TO SUPPORT INSPECTION #2018_630589_0011 DATED DECEMBER 21, 2018 - DUE DATE APRIL 2, 2019. [s. 19. (1)]

4. The licensee has failed to ensure resident #007 was free from neglect by staff in the home.

Ontario Regulations 79/10, s. 5 indicated neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The MOHLTC received an identified critical incident, on an identified date, related to resident #007 sustaining an injury of unknown cause.

Record review indicated resident #007 was admitted to the home and was assessed using the home's annual MDS assessment tool.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help. Registered staff RN #132 attended the room, and documented that they observed the resident already out of their bed. According to the documentation, the RN went to the doorway and called a PSW for support. PSW #112 and RN #132 transferred the resident to their wheelchair, and brought them to the nurses' station for monitoring. The resident was noted to have an injury on a identified body part. RN #132 documented that they called Nurse Practitioner #114 who was onsite to assess the resident. RN #132 was unavailable for an interview during this inspection.

During an interview, Nurse Practitioner (NP) #114 verified that they attended the unit, assessed the resident and wrote an order to transfer to hospital for further assessment related to the identified injury.

Record review indicated, and an interview with registered staff RPN #117 verified the resident was transferred to hospital for further assessment and treatment; however the resident was sent back to the home with a diagnosis which was unrelated to the identified injury.

During an interview, registered staff #117 verified that on an identified date, they observed the resident's injury and decided to entered the resident's name in the physician's book to be seen the follow day.

A review of the physician order form dated the following day, indicated that the physician wrote ordered a diagnostic test which confirmed the suspected diagnosis.

Record review of the progress notes indicated that on a later identified date, resident #007 was transferred back to the hospital for reassessment and treatment of the identified diagnosed injury. The resident received the required treatment and was returned to the home.

During an interview, PSW #112 verified that they provided personal care to the resident during the morning of the observed injury; and noted the resident did not have that or any other injury at that time. The PSW stated they were called to the

room by RN #132 to assist with the resident at the time of the incident. According to the PSW, when they entered the room, the resident was already out of their bed. PSW #112 verified that the resident was normally transferred to their wheelchair using a Hoyer lift; however, this was the first time transferring the resident without using the Hoyer lift. The PSW verified that the resident did not have a specific safety devices at the bedside at the time of the incident.

During an interview, the resident's SDM stated that they believe the resident got up and fell or possibly struck the identified body part against something. According to the SDM, they had requested safety devices since the resident had experienced a similar incident on a previously identified date; however the home did not provide the safety devices and they were still waiting to hear back from the home about their request.

During an interview, the private companion verified that the resident frequently tried to climb out of bed, that they were concerned about leaving the resident unattended, that the SDM had requested safety devices to prevent further incidents; and that they had not seen the resident standing and supporting their own body weight since their legs were weak from previous injuries.

During separate interviews, ADOC #113 and the DOC verified that an investigation was not completed related to the incident of unknown injury. Both agreed that an investigation should have been completed. In addition, the ADOC, who was also the Fall Prevention Program Lead verified that the resident should have had preventative devices in place. And that they were not aware of the family's request for safety devices which would have been provided. Therefore, the home failed to provide the resident with the treatment, care and assistance required, which resulted in a pattern of inaction that jeopardized the health, safety and well-being of the resident.
THIS EVIDENCE WILL BE USED TO SUPPORT INSPECTION #2018_630589_0011 DATED DECEMBER 21, 2018 - DUE DATE APRIL 2, 2019. [s. 19. (1)]

DR # 001: The above written notification is also being referred to the Director for further action by the Director.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The MOHLTC received a critical incident report related to resident #007 incidence of unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help. Registered staff RN #132 attended the room, and documented that they observed the resident already out of their bed. According to the documentation, the RN went to the doorway and called a PSW for support. PSW #112 and RN #132 transferred the resident to their wheelchair, and brought them to the nurses' station for monitoring. The resident was noted to have an injury on a identified body part.

Record review of the home's electronic risk management system indicated the absence of a risk management incident report related to resident #007 incident of unknown injury.

During an interview, the DOC verified that registered staff RN #132 should have completed the electronic risk management report related to the incident; however they were not able to locate the completed document. The DOC verified that an electronic risk management report should have been completed by the registered staff. [s. 30. (2)]

WN #10: 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 staff used safe transferring and positioning devices or techniques when assisting residents.

The MOHLTC received a critical incident report related to resident #007 sustaining an unknown injury.

Record review indicated resident #007 was admitted to the home and was assessed using the home's annual MDS assessment too.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help. Registered staff RN #132 attended the room, and documented that they observed the resident already out of their bed. According to the documentation, the RN went to the doorway and called a PSW for support. PSW #112 and RN #132 transferred the resident to their wheelchair, and brought them to the nurses' station for monitoring. The resident was noted to have an injury.

During an interview, PSW #112 verified that they provided personal care to the resident during the morning of the incident; and noted the resident did not complain of or show signs of any injury. The PSW stated they were called to the room by RN #132 to assist with the resident, when the resident was found out of bed. When they entered the room, the resident was already out of their bed. The PSW verified that the resident was normally transferred to their wheelchair using a Hoyer lift; however, during this instance, they transferred the resident to their wheelchair without using a Hoyer lift since the resident was already out of their bed.

During an interview, the resident's private companion stated that they had not seen the resident standing and supporting their body weight; and that the resident was very weak in their legs especially after experiencing multiple injuries to various body parts and had been bedridden for months. RN #132 was not available for an interview during the inspection period.
THIS EVIDENCE WILL BE USED TO SUPPORT INSPECTION #2018_630589_0011 DATED DECEMBER 21, 2018 - DUE DATE APRIL 26, 2019. [s. 36.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the incident, type of incident, area or location of the incident, date and time of the incident, and events leading up to the incident.

The MOHLTC received a critical incident report related to resident #007 sustaining an injury.

A review of the critical incident and progress notes indicated the following information was incorrect or missing:

-Date and time of the critical incident was listed as an identified date and time; however the actual date and time of the incident was on a different identified date and time.

-Events leading up to the critical incident were not included in the Critical Incident Report submitted to the MOHLTC. The actual events leading up to the critical incident were as follows:
-on an identified date and time, resident #007 was heard calling out for help in their room. Registered staff RN #132 attended the room, and observed the resident was already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support. The PSW and RN transferred the resident to their wheelchair, and brought them to the nurses' station for monitoring. Shortly after, the RN called the Nurse Practitioner who was onsite, to assess the resident after they observed that the resident had an identified injury. Therefore, the home failed to ensure that the report to the Director included the actual date and time of the incident, and events leading up to the incident. [s. 104. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

Record review indicated and staff interview verified that on an identified date, resident #002 and resident #001 had an altercation. The registered staff documented that they initiated a specific monitoring of the resident's condition, which was to be done on a paper document.

During an interview, registered staff RPN #109 verified that they initiated the monitoring as per the home's policy; however the specific monitoring record could not be located by the registered staff, Falls Program lead, and the home's DOC. All staff verified that the document should have been filed and available in the resident's paper chart.
Therefore, the home failed to ensure that resident #001 monitoring record was retained by the home. [s. 233. (1)]

2. Record review of the PCC progress notes indicated that resident #003 was involved in multiple resident-to-resident altercations over the past months. The resident was involved in altercations with other residents on multiple identified dates. The documentation indicated that a specific kind of monitoring was initiated after each incident.

During an interview, the support team RPN verified that duration of monitoring was assigned an specific number of days; and that since the middle of last year, that specified type of monitoring was completed on paper versus electronic documentation in POC.

Record review of the resident's paper chart indicated there were no specified type of monitoring forms located related to two of the identified altercations.

During an interview, the DOC verified that they were not able to locate the requested documents on those specified dates; however the records should have been filed in the residents chart. Therefore, the home failed to ensure resident #003's DOS monitoring records were retained by the home. [s. 233. (1)]

Issued on this 8 th day of April, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by VERON ASH (535) - (A2)
Inspection No. / No de l'inspection :	2019_324535_0003 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	030057-18, 031988-18, 001767-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 08, 2019(A2)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 Midland Avenue, SCARBOROUGH, ON, M1N-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kris Coventry

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Ministère de la Santé et des Soins de longue durée

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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee must be compliant with s. 55 (a) of the Ontario Regulations.

Specifically, the licensee must ensure procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #003's behaviors, including responsive behaviors, to minimize the risk of altercations and potentially harmful interactions between and among residents by completing the following:

1. Review the home's electronic responsive behavior referral protocol/process and develop a quality improvement audit to ensure all direct care registered staff have a full understanding of the referral process as it relates to resident #003; and all other applicable residents with displayed responsive behaviors. Document the registered staff review by way of an attendance list.

2. Review the home's internal and external behavioral support protocols and develop a quality improvement audit to ensure all direct care registered staff have a full understanding of when to refer residents displaying responsive behaviors to the home's internal BSO team versus the external psycho-geriatric outreach program (POP) to ensure residents' displaying responsive behaviors are addressed effectively and in a timely manner by registered staff. Document the registered staff review by way of an attendance list.

Grounds / Motifs :

1. The licensee has failed to ensure procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident report related to resident #003's responsive behaviors which caused injuries to residents and staff in the home.

Record review of the progress notes indicated that resident #003 was involved in multiple episodes of resident-to-resident physical altercations over a few identified

months. The inspector reviewed the resident's documented responsive behaviors over an identified period during those months because another resident in the home reported a previous altercation which occurred on an earlier identified date.

During an interview, registered staff RPN #115 stated the resident usually displayed responsive behaviors; however over the past months, the resident displaying more behaviors and does not recall the incidences when asked. According to PSW #111, the resident would display a behavior if they were upset. The PSW also verified that this information was not identified and documented in the resident's plan of care for all to be aware.

During an interview, the support team RPN verified that the resident should have been reassessed by the external support team with the intent to receive an evaluation and referral to another facility for assessment and treatment.

During an interview, ADOC #102 stated that they were not aware of the number of altercations involving resident #003. The ADOC verified that resident #003 should have been reassessed by the external support team. Therefore, the home failed to ensure procedures and interventions were implemented to assist residents and staff who were at risk of harm as a result of resident #003's displayed behaviors. [s. 55. (a)]

The severity of this issue was determined as actual harm/risk to the resident. The scope of the issue was isolated to a single resident. The licensee had a previous findings of non-compliance with this section of the Ontario Regulations in October 2017 that included inspectors issuing a voluntary plan of corrections (VPC) in Inspection #2017_630589_00015. As such, a Compliance Order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure that interdisciplinary staff collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other.

The compliance plan shall include but is not limited to the following:

1.Develop, implement and keep a record of the plan to ensure that PSWs are consulted when developing plans of care and identifying triggers for resident #002, #003 and #007, and other residents with displayed responsive behaviors.

2. Ensure timely communication with BSO and external resources at the onset of behavior assessment to prevent further incident.

3. Ensure interdisciplinary communication with the falls prevention team lead and the responsive behaviors team lead to secure and implement devices and appropriate interventions in a timely manner to prevent further injury to residents.

4. Develop and implement a quality management protocol/process to ensure collaboration is demonstrated across all disciplines.

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

The plan shall be submitted to the Long Term Care Home Inspector: Veron Ash by Friday, March 29, 2019 via email to: TorontoSAO.moh@ontario.ca

Grounds / Motifs :

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

The MOHLTC received a critical incident report related to resident #002's responsive behavior which caused an injury to resident #001.

Record review of the progress notes indicated over an identified period of months after resident #002's admission to the home, they were involved in multiple altercations with resident #001.

During separate interviews, RPN #107 and PSW #123 verified that they both had concerns related to resident #002's displayed responsive behavior on the unit.

During an interview, support team RPN #105 verified that they were not aware of some behavior incidents on identified dates since they did not receive an electronic referral from the registered staff working on the unit. The support team RPN also verified that although they were aware of the other incidences, they did not consult with the external support team for further assessment and recommended treatments. The support team RPN verified that they sent a referral to the support team after the last incident which resulted in an injury to resident #001.

During an interview, ADOC #102 verified that they were not aware of resident #002's displayed behaviors, nor were they aware of the staff concerns regarding the same. Furthermore, the ADOC verified that the registered staff should have submitted a referral to the internal support team for assessment after each incident.. As well, after the second incident occurred, if beyond their scope, the support team RPN should have referred the resident to the external support team for further assessment and recommended treatment. The ADOC agreed that there was no collaboration between members of the interdisciplinary teams in order to enure that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)] (535)

2. The Ministry of Health (MOH) received a critical incident report related to resident #003's behaviors.

Record review of the progress notes indicated that resident #003 was involved in altercations with other residents in the home on multiple identified dates.

During an interview, the resident's primary PSW #111 stated that the resident wants to be treated with respect. The PSW believed that this information could be an important identified triggers related to the resident's relationship toward others. The PSW also noted that this information should be identified and documented in the resident's plan of care so that everyone could become aware. After reviewing the resident's electronic kardex, the PSW verified that the resident's identified trigger was not included in the resident's Kardex for everyone to be able to access. Furthermore, PSW #111 stated that PSWs were the key to providing residents' care; however the home does not speak with them when developing the residents' plan of care. They reiterated that the team should have a discussion with primary PSWs about their residents because they work with those residents and knew them best.

During an interview, support team RPN #105 verified that they were not aware of some of the resident #003's altercations with others. However, during interviews with staff on the unit, they stated that although they did not consistently complete an electronic referral and send to the support staff, the support team RPN was notified of the altercations by other means.

During an interview, ADOC # 102 stated that they were not aware of the number of altercations involving resident #003. The ADOC verified that resident #003 should have been assessed after each incident, and their triggers identified by the team so that strategies could be introduced to mitigate further incidences. In addition, the ADOC stated that the resident should have been referred to the external support team for reassessment and recommendations. Therefore, the home failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)] (535)

3. The MOHLTC received a critical incident report related to resident #007's incident of unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling out for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support because the resident who was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring. The resident was noted to have an injury on an identified part of the body.

During an interview, ADOC #113, who was also the Fall Prevention Program Lead verified that the resident should have had fall prevention strategies in place at the time of their admission into the home, since they were assessed to be at high risk for falls. The ADOC also verified that they were not aware of the family's request to have a specific device applied to the resident's bed, which would have been provided after an assessment and consent by the family. The ADOC acknowledged that the registered staff should have discussed the resident's needs and the SDM's request with the Falls Prevention Program Lead to ensure collaboration of the resident's care and prevent resident #007 from getting out of bed again, thereby preventing the injury. [s. 6. (4) (a)] (535)

(A1)
4. The MOHLTC received a critical incident related to resident #007 incident of unknown injury.

Record review indicated resident #007 was admitted to the home and received an assessment using the home's annual MDS assessment tool.

Record review of the progress notes, medication administration records, and intake records indicated and staff interviews verified that resident #007 was usually well behaved at times; however, the resident often displayed responsive behaviors. The resident's written care plan included some information; however there was no indication that the resident was referred to the home's support team for appropriate interventions.

During an interview, the home's support team RPN #105 verified that the resident was not referred to the support team. Furthermore, the RPN stated that residents who display responsive behaviors should be referred to the support team for supportive interventions.

The severity of this issue was determined as minimum harm or potential for actual harm. The scope of the issue was widespread with multiple residents were affected. The licensee had three previous findings of non-compliance with this section of the LTCHA in February 2017 that resulted in inspectors issuing a compliance order (CO) in Inspection #2017_324535_0023; May 2017 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2017_644507_0003; and October 2017 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2017_630589_0015. As such, a Compliance Order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23 (1) of the LTCHA, 2007.

Specifically, the licensee must ensure every alleged, suspected or witnessed incident of abuse by anyone; or neglect of a resident by the licensee or staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated, appropriate action is taken in response to every such incident, as related to resident #004, #005, and #007; and all other residents who reside in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

The MOHLTC received a critical incident report related to resident #004 sustained injury which required first aid treatment.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, PSW #129 observed resident #003 asleep in another resident's room. The PSW redirected the resident to their own room. Resident #003 became upset and had an altercation with two separate residents as they were leaving the room. Resident #004 was one of those residents who sustained an injury to an identified body part. Resident #004 was treated with first aid. Resident #003 was redirected to their room with close monitoring by a PSW.

During an interview, ADOC #102 verified that the incident occurred and that there was no investigative notes available related to the incident. The ADOC also indicated that the altercation was considered abuse of resident #004 by resident #003. [s. 23. (1) (a)] (535)

2. The MOHLTC received a critical incident report related to resident #005 sustained an injury which required first aid treatment and clinical monitoring.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, PSW #129 observed resident #003 asleep in another resident's room. The PSW redirected the resident to their own room. Resident #003 became upset and had an altercation with two separate residents as they were leaving the room. Resident #005 was one of those residents, who sustained an injury to an identified body part. Resident #005 was treated with first aid and close monitoring. Resident #003 was redirected to their room with close monitoring by a PSW.

During an interview, ADOC #102 verified that the incident occurred and that there was no investigative notes available related to the recent incident. The ADOC also indicated that the altercation was considered abuse of resident #005 by resident #003. [s. 23. (1) (a)] (535)

3. The MOHLTC received a critical incident report related to resident #007 sustaining an unknown injury.

Record review indicated resident #007 was admitted to the home and was assessed using the home's annual MDS assessment tool.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury to an identified part of the body. RN #132 was unavailable for an interview during the period of this inspection.

During separate interviews, the Director of Care and ADOC #113 verified that an investigation was not completed related to the incident of unknown injury; and both agreed that an investigation should have been completed. [s. 23. (1) (a)]

The severity of this issue was determined as minimum harm or potential for actual harm. The scope of the issue was widespread with multiple residents affected. The licensee compliance history indicates one or more unrelated findings of non-compliance in the last 36 months. As such, a Compliance Order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019(A2)

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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s. 50 (2) of the Ontario Regulations, 2010.

Specifically, the licensee must ensure applicable residents at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, and reassessed at least weekly by a member of the registered nursing staff, if clinically indicated by completing the following:

1. Review with all registered staff the home's skin and wound care assessment protocol related to identified areas of altered skin integrity introduced in 2018; and ensure staff fully understand by maintaining an attendance list.

2. Ensure the home's Skin and Wound Care Policy includes the updated information and reference specific assessment documents to be completed by registered staff; and that staff has access to the updated policy.

3. Develop and implement monthly quality improvement audit of residents' assessment related to identified areas of altered skin integrity. The audit is to include but not limited to the following information: unit name, date of audit, person completing the audit, resident assessment audited, outcome of audit, follow up actions; and other relevant information included.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The MOHLTC received a critical incident report related to resident #002's responsive behaviors which caused an injury to resident #001.

Record review indicated and staff interview verified that on an identified date and time, resident #002 and resident #001 had an altercation in their room which resulted in an injury with altered skin integrity to resident #001 identified body part. The resident was transferred to hospital; and returned to the home on an identified date with a specified diagnosis.

Record review indicated that on an identified date, the registered staff documented in the electronic progress note that the resident had an altered skin integrity; however the staff did not complete an electronic assessment which was required; and did not document the altered skin integrity in the resident's electronic treatment assessment record (TAR) for monitoring.

Record review also indicated that on an identified date, registered staff #107 completed the electronic assessment; however there was no further weekly assessment completed for the resident related to the altered skin integrity as verified by the Skin and Wound Care Lead. [s. 50. (2) (b) (iv)] (535)

2. The MOHLTC received a critical incident report related to resident #007's unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling for help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury with altered skin integrity to an identified part of the body.

Record review also indicated that PSWs documented the altered skin integrity during their shifts; however registered staff did not completed the electronic assessment,

nor did they complete assessments related to the resident's altered skin integrity as verified by the Skin and Wound Care Lead.

During an interview, Skin and Wound Care Lead #106 verified an assessment should have been completed by the registered staff on the same identified date as the incident occurred. Furthermore, the Skin and Wound Care lead verified the following:

-the home switched to a new electronic documentation system; and the new system does not auto-generate scheduled assessments to alert registered staff to complete altered skin integrity assessments;
-it was currently difficult to track the treatment of some forms of altered skin integrity in the home; and,
-altered skin integrity should be documented by registered staff using the progress notes and appropriate assessment tools; however, although training was provided, registered staff was not consistently completing both documents.
Therefore, the home failed to ensure that residents #002 and #007's altered skin integrity were reassessed at least weekly by a member of the registered nursing staff as clinically indicated. [s. 50. (2) (b) (iv)]

The severity of this issue was determined as minimum harm or potential for actual harm. The scope of the issue was patterned. The licensee had three previous findings of non-compliance with this section of the Ontario Regulations in December 2016 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2016_353589_0016; May 2017 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2017_430644_0004; and December 2018 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2018_630589_0011. As such, a Compliance Order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. 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.

Order / Ordre :

The licensee must be compliant with s. 54 (a) of the Ontario Regulations, 2010.

Specifically, the licensee must ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, 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 identifying and implementing interventions by completing the following:

1. Review with all registered staff the home's responsive behavior electronic referral and document by way of an attendance list, to ensure staff use the appropriate mode of contact to inform the home's internal BSO team of residents' responsive behaviors.

2. Develop, document and implement a plan that will ensure registered staff and the BSO team respond to identified responsive behaviors in a timely manner to prevent residents from potentially harmful interactions with other resident exhibiting such behaviors.

3. Develop and implement random monthly quality improvement audits of residents' plan of care to ensure behavior triggers are identified and communicated to all direct care staff. The audit should include, but not limited to the following information: unit name, date of audit, person completing the audit, behavior assessment completed if applicable, method of contact with BSO team, behavior triggers documented in written care plan with appropriate interventions, outcome of audit, follow up actions; and other relevant information as required.

Grounds / Motifs :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercation and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

The MOHLTC received a critical incident report related to resident #002's responsive

behaviors.

Record review of the progress notes indicated that over a period of identified months since resident #002's admission to the home, they were involved in three resident-to-resident altercations involving resident #001.

During an interview, support team RPN #105 stated the team had identified that resident #002 had an identified responsive behavior. The RPN also verified that after the first two incidences, the resident was assessed; however the support team RPN did not implement change in interventions nor consulted with the external support team for further assessment because the resident was not injured; and both residents resettled with no further incident. After the final incident on an identified date, the external support team was consulted and interventions were put in place, and both residents were separated.

During an interview, ADOC #102 stated that if a resident's responsive behaviors were beyond the scope of the support team RPN, they should have followed the home's Protocol and consulted with the external support team team for further assessment and recommended treatment. The ADOC verified that further assessment and interventions should have being implemented prior to the third incident. Therefore, the home failed to ensure steps were taken to minimize the risk of altercation and potentially harmful interactions between residents. [s. 54. (a)]

The severity of this issue was determined as actual harm of the resident. The scope of the issue was isolated. The licensee had two previous findings of non-compliance with similar section of the Ontario Regulations in December 2016 that resulted in inspectors issuing a compliance order (CO) in Inspection #2016_353589_0016; and December 2018 that resulted in inspectors issuing a voluntary plan of compliance (VPC) in Inspection #2018_630589_0011. As such, a Compliance Order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (5) of the LTCHA, 2007.

Specifically, the licensee must ensure that the resident, the resident's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker are provided an opportunity to participate in the development and implementation of the resident's plan of care by completing the following:

1. Develop, document, communicate, and implement a communication plan to ensure residents' substitute decision makers (SDMs) are contacted by a member of the management team or designate after each reported incident, especially if a resident sustained an injury. The SDM will be provided the opportunity to discuss the incident and participate in the development and implementation of the resident's plan of care as related to resident #002 and #007; and all other residents residing in the home.

2. Ensure resident #007's SDM participation in the resident's plan of care by applying as appropriate, the requested bedside rails to the resident's bed in accordance with the home's policies.

Grounds / Motifs :

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

The MOHLTC received a critical incident report related to an incident with resident #002 and resident #001.

Record review of the progress notes indicated over a period of four months since resident #002's admission, the two were involved in three altercations.

Record review indicated and staff interview verified that at the time of notification of the second incident, resident #001's SDM requested a follow up plan to ensure the resident would be safe with no further incidents. However, on another identified date when the third incident occurred, resident #001 sustained an injury and was transferred to the acute care hospital.

During an interview, ADOC #102 verified that they were aware that resident #001's SDM had expressed concerns related to resident #002. However, they went on vacation from during a specified time period and returned on the day of next incident. ADOC #102 verified that they do not believe the family was contacted with a plan to be implemented to protect resident #001; and they had not spoken with the family regarding the same prior to leaving for vacation. Therefore, the home failed to ensure the SDM was provided the opportunity to participate fully in the development and implementation of resident #001 plan of care. [s. 6. (5)] (535)

2. The MOHLTC received a critical incident report related to resident #007's sustaining an unknown injury.

Record review of the progress notes and the critical incident report indicated that on an identified date and time, resident #007 was heard calling help in their room. Registered staff RN #132 attended the room, and documented that they observed the resident already out of bed. According to the documentation, the RN went to the doorway and called a PSW for support since the resident was usually bedridden. PSW #112 and RN #132 transferred the resident to the wheelchair, and brought them to the nurses' station for monitoring.The resident was noted to have an injury to an identified part of the body.

During an interview, the resident's SDM stated that they believe the resident may have tried to get up from the bed and possibly struck the identified body part against something. According to the SDM, they requested a specific safety device for the resident after the resident's previous incident when they sustained an injured; however they stated the home did not provide the safety device requested. The SDM verified that they were still waiting to hear back from the home about their request which would have prevented this recent incident and prevented further injury.

During an interviews, the ADOC, who was also the Fall Prevention Program Lead verified that the resident should have had Fall Prevention strategies in place at the time of their admission into the home, since they were assessed to be high risk for falls. The ADOC acknowledged that the home failed to ensure the resident's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care by not respecting and granting their request which would have prevented further injury. [s. 6. (5)]

The severity of this issue was determined as minimum harm or potential for actual harm. The scope of the issue was isolated. The licensee had a previous findings of non-compliance with this section of the LTCHA in May 2017 that included inspectors issuing a voluntary plan of corrections (VPC) in Inspection #2017_644507_0003; October 2017 that included inspectors issuing a voluntary plan of corrections (VPC) in Inspection #2017_630589_0015; and December 2018 that included inspectors issuing a voluntary plan of corrections (VPC) in Inspection #2018_630589_0011 As such, a Compliance Order is warranted. (535)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jun 10, 2019(A2)

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:

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

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

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 8 th day of April, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by VERON ASH (535) - (A2)

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