Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 6, 2019	2019_650565_0009	031286-18, 032712-18, 000616-19, 000617-19, 000618-19, 000619-19, 001754-19, 005341-19	Complaint

Licensee/Titulaire de permis

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

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

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

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

MATTHEW CHIU (565), IVY LAM (646), JOANNE ZAHUR (589), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, and 23, 2019.

During the course of the inspection, the following Complaint Inspection intake logs were inspected:
- 031286-18 related to infection prevention and control, and improper care of

resident,
- 032712-18 related to bed refusal for resident,
- 001754-19 related to reporting and complaints, and improper falls prevention and management for resident, and
- 005341-19 related to improper nutrition and hydration care for resident.

During the course of the inspection, the following Follow-Up intake logs were inspected:
- 000616-19 for CO #001 related to compliance with duty to protect,
- 000617-19 for CO #002 related to compliance with reporting certain matters to Director,
- 000618-19 for CO #003 related to compliance with safe transferring and positioning techniques, and
- 000619-19 for CO #004 related to compliance with maintenance services.

During the course of the inspection, Critical Incident System (CIS) intake log #001992-19 was inspected by inspector #649 during inspection #2019_650565_0010. Finding of noncompliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) related to resident #009, and it is issued together with the non-compliances of this inspection.

During the course of the inspection, Complaint intake log #000572-19 was inspected by inspector #565 during inspection #2019_650565_0011. Finding of noncompliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) related to resident #004, and it is issued together with the non-compliances of this inspection.

During the course of the inspection, Complaint intake log #006816-18 was inspected by inspectors #502 and #589 during inspection #2019_630589_0013. Findings of noncompliance were identified under LTCHA, 2007 S.O. 2007, c.8, s. 22. (1) and O. Reg. 79/10, s. 101. (1) 3. related to resident #012, and they are issued together with the non-compliances of this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Food Services (DFS), Quality and Informatics Partner (QIP), Registered Dietitian (RD), Interim Resident Relations Coordinator (IRRC), Recreation therapist (RT), Cook, Nurse Manager (NM), Behavioural Supports Ontario Nurse (BSON),

Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aide (DA), Housekeeping Aide (HA), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #001	2018_630589_0011	649
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2018_630589_0011	589
O.Reg 79/10 s. 36.	CO #003	2018_630589_0011	565
O.Reg 79/10 s. 90. (2)	CO #004	2018_630589_0011	589

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in care of resident #026 collaborated with each other in the development and implementation of the resident #026's plan of care related to the treatment of a specified diagnosis.

This inspection was initiated to inspect on a complaint received from the Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to the specified improper care for resident #026.

Record review revealed during an identified four-month period, resident #026 was supposed to receive the specified laboratory test on a regular basis. The records indicated that after two identified test results stating the identified issues were received by the home, the resident did not receive the repeated tests, and after another identified test result stating the identified issues was received by the home, the resident did not receive the repeated test until an identified number of days later.

Interview with PSW #114, the usual PSW for resident #026, stated it was part of the

resident #026's care to perform a specified intervention related to the above mentioned test, and they had not had any issues performing the intervention.

Interview with RN #143 stated that resident #026 had a history of the specified diagnosis, and had the above mentioned intervention and test on a regular basis. RN #143 further stated the identified responsibilities and collaboration among the PSW, registered staff, and the physician that related to the test. If there were issues with the results, an identified staff communication would ensure that a repeated test is done accordingly.

Interviews with ADOC #127 and the DOC indicated that if the specified laboratory test result for resident #026 had the identified issues, a repeated test should be done right away. There was no record demonstrating the registered staff collaborated with the PSWs or the physician in regards to the need to repeat the laboratory tests. ADOC #127 and the DOC confirmed that the staff did not collaborate in the implementation of the resident's plan of care related to assessment and treatment of the resident #026's specified diagnosis. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in three residents' plans of care were provided to the residents as specified in their plans.

a. The MOHLTC received a Critical Incident System (CIS) report related to an allegation of abuse that occurred on an identified date.

Review of the CIS report indicated that resident #009 was experiencing a specified health condition and asked PSW #129 for help. The report stated the identified interactions between PSW #129 and resident #009 who had demonstrated the specified responsive behaviours. After the incident, a specified care was implemented for the resident.

A review of resident #009's progress notes indicated that the specified care was started after the above incident. Further review of the home's records indicated the specified care was not provided to the resident on an identified shift.

Interview with the DOC indicated that the residents' plan of care consist of everything hard copy on the floor, all the information in point click care (PCC), and the PSW assessment and documentation. The DOC acknowledged that resident #009's plan of care was not followed on the identified shift. [s. 6. (7)]

b. The MOHLTC received a complaint related to resident #004's plan of care and significant injury of unknown cause diagnosed on an identified date.

Review of resident #004's plan of care, progress notes and post-fall assessments during an identified period revealed that the resident had risk for falls and fell on four identified dates. The post-fall assessment for the last fall stated that a specified intervention was put in place as one of the immediate actions to prevent re-occurrence.

Record review indicated the night before the above mentioned significant injury was diagnosed, PSWs #136 and #137 provided care to resident #004 in their room. The next morning, RPN #139 observed the resident sitting on the bedside, and no records mentioning the specified intervention was provided at that time.

Interviews with PSWs #136 and #137 indicated during their shift on the identified date, they provided the identified care to resident #004. They did not recall if the specified intervention was provided to the resident during the shift. PSW #137 further stated that they were not aware of use of the specified intervention until after the above mentioned significant injury.

Interview with RPN #139 indicated on the identified date, in the morning, they observed resident #004 sitting at the end of their bedside, and the RPN did not recall if the specified intervention was provided to the resident.

Interview with RN #140 indicated they recall the specified intervention had been provided to resident #004 since the above mentioned post-fall assessment. RN #140 further stated that they worked on the day shift on the identified date and no records indicated the specified intervention was provided to the resident on that day.

Interview with ADOC #101 indicated that the post-fall assessments are part of the home's plan of care. ADOC #101 confirmed that the specified intervention should have been provided to resident #004 on the identified date as specified in the post-fall assessment, but it was not provided as required. [s. 6. (7)]

c. The MOHLTC received a complaint on an identified date related to the falls prevention care and dealing with complaints for resident #003.

Review of resident #003's RAI-MDS assessment and the current plan of care during the time of this inspection revealed the resident had both cognitive and physical impairments.

The plan of care stated resident #003 was at high risk for falls, and a specified intervention was implemented as one of the falls prevention interventions.

Observations on an identified date and time revealed that the specified intervention was not provided to resident #003 as required by the plan.

Interviews with PSW #134, RPN #138, and RN #140 indicated that resident #003 was at risk for falls due to the identified contributing factors. The resident had the specified intervention implemented for falls prevention.

Observation together with PSW #134 on an identified date and time further indicated that resident #003 did not receive the specified intervention as required. After the observation, PSW #134 had provided the specified intervention to the resident.

Interview with ADOC #101 indicated that the falls prevention plan of care for resident #003 directed staff to provide the specified intervention to the resident. ADOC #101 acknowledged that the specified intervention was not provided to resident #003 as specified in the plan, as mentioned above. [s. 6. (7)]

3. The licensee has failed to ensure that resident #003's plan of care related to their falls prevention was revised when care set out in the plan has not been effective.

The MOHLTC received a complaint on an identified date related to the falls prevention care and dealing with complaints for resident #003.

Review of resident #003's RAI-MDS assessment and the current plan of care at the time of this inspection revealed the resident had both cognitive and physical impairments. The plan of care stated resident #003 was at high risk for falls.

Review of the falls history during an identified period revealed five identified falls, and the last three falls were related to an identified situation that leads to the falls.

Further review of resident #003's falls prevention plan of care indicated that it was last revised on an identified date before the last three falls.

Interviews with PSW #134, RPN #138, and RN #140 indicated that resident #003 was at risk for falls because of the identified contributing factors. The staff members further stated that resident #003's falls prevention interventions may help reduce the number of

falls but they may not be effective preventing their falls from the identified situation that leads to their last three falls. The staff members did not recall any change in resident #003's falls prevention plan of care after the above mentioned last revision.

Interview ADOC #101 indicated the falls prevention care for resident #003 was able to reduce their number of falls, but in the last quarter, the resident had several falls related to the identified situation as mentioned above. ADOC #101 stated the fall prevention plan of care had not been revised after the last three falls.

ADOC #101 acknowledged that resident #003's fall prevention plan of care was not revised when the care set out in the plan had not been effective for preventing the resident's falls related to the above mentioned identified situation. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
- the care set out in the plan of care is provided to the resident as specified in the plan, and
- the resident's plan of care is revised when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that they had been received concerning the care of residents were immediately forwarded to the Director.

a. The MOHLTC received a complaint on an identified date which indicated several concerns and one of them was related to the home's food production.

A review of the home's complaint record binder indicated the Long-Term Care home (LTCH) had received a written complaint on an identified date from residents #015 and #012 which indicated food was being served cold during meal service. A further review of the LTCH's complaint record indicated that this written complaint had been forwarded to the central intake assessment and triage team (CIATT) by the LTCH. A review of the compliance smart client web-home (CSC) server conducted by the inspector did not indicate the written complaint had been received. A further review conducted directly with CIATT, indicated the written complaint had not been received by them.

During an interview, the DOC could not provide verification that the LTCH had submitted the above mentioned written complaint to CIATT as per legislative requirements. [s. 22. (1)]

b. The MOHLTC received a complaint on an identified date related to the plan of care and dealing with complaints for resident #003.

Interview with a family member of resident #003 revealed that they had sent several emails to ADOC #101 concerning the care of the resident. The family member further stated two identified emails were complaints concerning resident #003's care, and they did not recall receiving any responses from the home.

Review of the above mentioned emails indicated that they were complaints related to the identified care issues for resident #003.

Review of the home's complaint records did not indicate the above complaints had been forwarded to the Director.

Review of ADOC #101's email responses and interview with ADOC #101 indicated that they were involved with the communications with resident #003's families concerning the resident's care, and emails were part of the communications.

ADOC #101 stated the above emails were written complaints concerning resident #003's care and confirmed that they had not forwarded the written complaints to the Director, as required. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that licensee of a long-term care home who receives a written complaint concerning the care of a resident shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of residents or operation of the home, a response had been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

a. The MOHLTC received a complaint on an identified date indicating several concerns related to resident #012's care.

During a telephone interview, the complainant stated that the LTCH has not been following up with them when concerns have been previously voiced.

A review of the LTCH's complaint binder and progress notes during an identified period for resident #012 did not indicate any documented responses and/or follow-ups to the complainant's identified concerns mentioned above.

During a conversation, the DOC acknowledged that they had been told by the complainant that they had not received any follow-ups to their concerns from the previous DOC, who no longer works in the LTCH. [r. 101. (1) 3.]

b. The MOHLTC received a complaint on an identified date related to the falls prevention care and dealing with complaints for resident #003.

Interview with a family member of resident #003 revealed that they had sent several emails to ADOC #101 concerning the care of the resident. The family member further stated two identified emails were complaints concerning resident #003's care, and they did not recall receiving any responses from the home.

Review of the above mentioned emails indicated that they were complaints related to the identified care issues for resident #003.

Review of the home's complaint records and ADOC #101's email responses indicated email responses were given to the family member in response to one of the identified complaint. No records indicating the home had responded to the second above mentioned complaint.

Interview with ADOC #101 indicated the above mentioned emails were written complaints concerning resident #003's care. ADOC #101 confirmed that they missed the second email compliant and no response was made by the home to the family as required. [s. 101. (1) 3.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with every order made under this Act.

a. On December 21, 2018, a compliance order (CO) was issued under inspection #2018_630589_0011 and made under LTCHA, 2007 S.O. c.8, s. 19. (1) as follows:

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

Specifically the licensee must:
(a) Prepare and implement a plan to ensure the emotional needs of resident #009 regarding any incidents of abuse are assessed and appropriate interventions for care are implemented
(b) Ensure that all front line staff are trained on the licensee's prevention of abuse policy

and understand the definitions that constitute verbal and emotional abuse
(c) Ensure that specifically, PSW #179 is retrained on behavior management, including caring for persons with dementia
(d) Keep a documented record of the education material/ components provided, staff that attended, the date(s) the education was provided and whom provided the education and
(e) Maintain a documented record of each decision made pertaining to any residents' internal transfers including temporary room changes. Also, include the rationale for the decision made by the interdisciplinary team, staff involved in the decision and the date the decision was made.

The compliance date was April 2, 2019.

During this inspection it was found that the home completed steps (a), (c), (d), and (e) but failed to complete step (b).

A review of the training records for all front line staff provided by the home, indicated that 56 percent of front line staff completed the training on the licensee's prevention of abuse policy, including the definition of verbal and emotional abuse. 44 percent of front line staff had not completed the required training.

In an interview with QIP #113, they acknowledged that 44 percent of front line staff had not completed the required training.

In an interview with the DOC, they acknowledged that not all the required staff completed the required training. [s. 101. (3)] (649)

b. On December 21, 2018, a CO was issued under inspection #2018_630589_0011 and made under LTCHA, 2007 S.O. c.8, s. 24 (1) as follows:

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

The licensee was ordered to:
(a) ensure all managers and registered staff are provided with education on s. 24 (1) of the LTCHA related to criteria based on Reporting Certain Matters to the Director, and
(b) the LTCH is to keep a record of the education material presented, date(s) the education was provided, staff that attended and who provided the education.

The compliance date was April 2, 2019.

During this inspection it was found that the home completed step (b), but failed to complete step (a).

A review of the staff education attendance records indicated that all the managers had received the required education however, 18 out of 69 registered staff did not receive the education, indicating 26 percent failed to meet the compliance due date of April 2, 2019.

During a conversation, QIP #113 acknowledged the home had failed to meet the education requirements for the compliance order by the compliance date of April 2, 2019. [s. 101. (3)] (589)

c. On December 21, 2018, a CO was issued under inspection #2018_630589_0011 and made under O. Reg. 79/10, r. 90. (2) (g) as follows:

The licensee must be compliant with r. 90 (2) (g).

Specifically, the licensee must:
(a) ensure all registered staff and front line staff are provided education on the home's policy #VII-H-10.70 titled: Water Temperature Monitoring and when temperatures are below 40degrees Celsius or exceed 49 degrees Celsius, what steps to take and the interventions to be implemented when water temperatures are not within acceptable guidelines,
(b) develop and implement audits to ensure that the temperature of the hot water serving all bathtubs, showers, and sinks used by residents will be monitored daily and once per shift in random locations where residents have access to hot water. The audit should include who completed the audit, any actions required and the date the audit was completed, and
(c) develop and implement a reporting system that identifies who is specifically be notified when water temperatures are not within acceptable guidelines in the absence of the Director of Environmental Services.

The compliance date was April 2, 2019.

During this follow-up inspection, the licensee completed steps (b) and (c), but they failed to complete step (a).

A review of the staff education attendance records indicated that 97 out of 223 registered

and front line staff did not receive the education, indicating 34 percent failed to meet the compliance due date of April 2, 2019.

During a conversation, QIP #113 acknowledged the home had failed to meet the education requirements for compliance order by the compliance date of April 2, 2019. [s. 101. (3)] (589)

d. On Dec 21, 2018, a CO, was issued under inspection #2018_630589_0011 and made under O. Reg 79/10, s. 36. as follows:

The licensee must be compliant with O. Reg. 79/10, r. 36. Specifically, the licensee shall:
(a) ensure PSWs #154, #162, #166 and all other PSWs are provided education on safe transferring, positioning devices or techniques and on strategies to request assistance without leaving the resident's side when providing care and assistance,
(b) ensure PSWs #154, #162, #166 and all other PSWs are provided education on the safe use of all mechanical lifts,
(c) keep a documented record of the education sessions provided that includes the material covered, date(s) of when the education was provided, staff that attended and who provided the education sessions, and
(d) develop and implement a documented auditing system that consists of audits of staff #154, #162, #166 and all other direct care staff providing care to ensure safe transferring and positioning devices or techniques are being used when assisting residents, that includes the date of the audit, who completed the audit, the outcome of the audit and any actions taken as a result of the audit.

The compliance date was May 2, 2019.

During this inspection, it was found that the home completed step (c), but failed to complete steps (a), (b), and (d).

Review of the home's education records for the above mentioned steps (a) and (b) revealed that the home had 154 PSWs required to receive the education by May 2, 2019. Further review of the records stated the following:
- One identified PSW, did not receive the required education until May 3, 2019, and
- Two additional identified PSWs did not receive the required education as of May 6, 2019.

Interviews with QIP #113 and ADOC #101 indicated that towards the end of the

compliance due date, they identified a few staff members did not receive the required education and they included the above mentioned PSWs.

QIP #113 and ADOC #101 confirmed, and the ED acknowledged that the above mentioned PSWs did not receive the required education by May 2, 2019, and the home had failed to meet the education requirements for the compliance order by the compliance date of May 2, 2019.

Review of the home's records for the auditing system related to the step (d) of the CO revealed that the home had implemented a Nurse Manager Daily Walk About audit to their direct care staff. The audit records did not consist of auditing staff #154 who was a PSW in the home during this inspection.

Interview conducted on on an identified date, after the compliance date, with PSW #154 indicated that their transferring and positioning techniques was not audited until the morning on the day of this interview.

Interviews with QIP #113 and ADOC #101 indicated that the home had tested using different auditing tools for the required audit in March and April 2019, and had implemented the required auditing system as of May 2, 2019. QIP #113 and ADOC #101 confirmed that the home's implemented auditing system did not consist of an audit of PSW #154 before the compliance due date, May 2, 2019. [s. 101. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to comply with every order made under this Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the denial of resident applicant #002's application for admission provided sufficient grounds on which the licensee is withholding approval.

A compliant was submitted to the MOHLTC on an identified date from the Local Integrated Health Network (LHIN). The complaint indicated a bed refusal challenge that included an written notice from the LTCH. The written notice cited the LTCH did not have the necessary resources to meet resident applicant #002's needs at this time citing the responsive behaviours could not be managed due to lack of staff expertise in the home.

A review of an identified behavioural assessment completed by the LHIN and provided to the LTCH indicated that applicant #002 exhibited several responsive behaviours and the assessment also indicated interventions to manage these responsive behaviours.

During an interview, the IRRC #103 stated that the LTCH does have an active responsive behaviour program in place, an internal behavioural nurse, access to Ontario Shores, Toronto Rehabilitation Institute, psychiatric outreach program nurse, and a pyscho-geriatrician. IRRC #103 also acknowledged that the LTCH has staffed trained in gentle persuasive approach and in physical, intellectual, emotional, capabilities, environmental and social needs training.

During an interview, the DOC acknowledged that the bed denial for applicant #002, citing that staff do not have the nursing expertise to manage responsive behaviours was not sufficient grounds to deny admission to the LTCH. [s. 44. (9) (a)]

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.