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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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
Nov 07, 2019	2019_808535_0010 (A1)	009132-17, 024790-17, 003801-18, 004733-18, 005254-18, 015839-18, 020577-18, 025946-18, 026115-18, 029054-18, 029840-18, 030261-18, 030343-18, 031204-18, 031629-18, 000989-19, 002755-19, 003251-19, 006365-19, 006366-19, 006367-19, 006368-19, 006369-19, 006370-19, 009563-19, 010289-19	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) - (A1)

Ontario

Ministry of Health and Long-Term Care

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

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee requested an extension of the due date from November 8, 2019 to January 31, 2020.

Issued on this 7 th day of November, 2019 (A1)

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

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

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

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130 Midland Avenue SCARBOROUGH ON M1N 4E6

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

Amended by VERON ASH (535) - (A1)

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): June 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 2019.

The following intakes were completed during this inspection: Log #s :009132-17 (related to neglect), 024790-17 (related to responsive behavior), 003801-18 (related to abuse), 004733-18 (related to neglect), 005254-18 (related to abuse), 015839-18 (related to responsive behavior), 020577-18 (related to outbreak), 025946-18 (related to injury of unknown cause), 026115-18 (related to responsive behavior), 029054-18 (related to injury of unknown cause), 029840-18 (related to injury of unknown cause), 030261-18 (related to elopement), 030343-18 (related to abuse), 031204-18 (related to injury of unknown cause), 031629-18 (related to responsive behavior), 000989-19 (related to abuse), 002755-19 (related to elopement), 003251-19 (related to injury of unknown cause), 006365-19 (related to follow up CO), 006366-19 (related to follow up CO), 006367-19 (related to follow up CO), 006368-19 (related to follow up CO), 006369-19 (related to follow up CO), 006370-19 (related to follow up CO), 009563-19 (related to medication), 010289-19 (related to neglect).

PLEASE NOTE: A Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 19 and Compliance Order related to LTCHA, 2007, c.8, s. 8, identified in two concurrent inspections #2019_808535_0011 and #2019_539120_0022 respectively, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOCs (ADOCs), Quality & Informatics Partner, Resident Assessment Instrument (RAI) Coordinator, Wound Care/Rehabilitation Nurse, Behavior Support Outreach (BSO) Nurse, Physiotherapy Assistant (PTA), Food Service Supervisor, scheduling clerk, receptionist, housekeeping staff, registered staff RN/ RPN; personal support worker (PSW), Substitute Decision Makers (SDMs) and residents.

During the course of the inspection, inspectors 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:

Critical Incident Response
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

9 WN(s)
3 VPC(s)
1 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. 23. (1)	CO #003	2019_324535_0003	535
O.Reg 79/10 s. 50. (2)	CO #004	2019_324535_0003	535
O.Reg 79/10 s. 54.	CO #005	2019_324535_0003	535
O.Reg 79/10 s. 55.	CO #001	2019_324535_0003	740
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #002	2019_324535_0003	535
LTCHA, 2007 S.O. 2007, c.8 s. 6. (5)	CO #006	2019_324535_0003	535

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had, instituted or otherwise put in place a plan, policy, protocol, procedure, strategy or system, the licensee was

required to ensure that the plan, policy, protocol, procedure, strategy or system b) was complied with. O. Reg. 79/10, s. 8 (1).

In accordance with O. Reg. 79/10, 90(1)(b), the licensee was required to have in place, procedures and schedules for routine, remedial and preventive maintenance. Confirmation was made that procedures and schedules for preventive maintenance were in place, but they were not complied with.

The following observations were made at the time of inspection:

1. Window glass in three dining rooms were cracked. According to the Building Services Partner, windows were not on the capital plan for replacement in 2019.

2. Wood trim on windows located at corridor ends and in dining rooms and resident rooms were peeling and some had dry rot. There was no plan in place to address this concern.

3. Wood hand rails in corridors on all floors were not in good condition as they were gouged and worn. No plans were in place to address this concern.

4. Tubs were not maintained in good operating order. Three tub models were not mechanical and were positioned directly on the floor. No water supply to the faucets was provided when they were turned on. Three tub models were designed with a door on the side of the tub for entry and exit. All three had articles inside of the tubs and two were identified to have broken parts and were not functional. One tub model, which was mechanical and very long, had broken parts and was not functional. No paperwork could be provided from 2018 that the tubs were inspected by the tub company. Seven out of the ten tubs were inspected on an identified date, after their condition was raised with the Executive Director. The other three tub models (non-mechanical) were not purchased from the same tub company, and the technician did not check them. No records could be provided by the DES that the tubs were inspected as per the homes procedures and schedule (monthly).

5. Bathroom vinyl sheet flooring lifted and rippled in but not limited to two identified resident washrooms. Many others had split seams under the bathroom vanities and the edges were lifting in two identified bathrooms. The DES was unaware of the condition.

6. Warped and rotted shelving under utility sinks in three identified floor dining rooms from water leaking. The DES was unaware of their condition.

7. Mouldy and water stained dry wall section (approx. 3 feet by 3 feet) located in the dried goods storage room. By end of day, the same area was covered over with a vinyl sheet instead of having the damaged drywall removed and replaced.

8. Over bed table was observed to be in use by resident in the corridor. It was missing a large section (6 cm by 6 cm) in one corner and was rough. An over bed table in a resident room was also in poor condition.

9. Door hinges on multiple bathroom doors in resident rooms on but not limited to a specific floor were very noisy.

10. A deep triangular shaped gouge approx. 10 cm x 5 cm was noted in the PVC floor tile on an identified floor in the dining room. The depression presented a hazard for tripping. The DES was unaware of the condition and was shown the area on an identified date.

11. Table bases in some of the dining rooms were rusted.

12. A section of wall paper in the dining room on the third floor (under a window) had peeled back and exposed some minor mould growth on the drywall. The DES was under the impression that they were not allowed to deal with mouldy surfaces. The DES was informed that any area of mould below ten square feet in size can be cleaned and managed by maintenance staff without any special qualifications.

13. Fruit flies were noted to be in excess inside of the main kitchen. The fruit flies were of a species that breed in drains and wet, damp areas (as opposed to within fruit). The Food Services Supervisor was not aware when and if the floor drains were ever cleaned. The task was under the maintenance department. According to the home's preventive maintenance schedule, floor drains were required to be checked or cleaned once per month. When access was provided to the home's electronic system of record keeping, no notations or evidence was available to indicate when or if someone conducted the task.
THIS FINDING WAS INCLUDED AS SUPPORTING EVIDENCE FROM INSPECTION #2019_539120_0022.

2. In accordance with Ontario Regulation 79/10, s. 230, required the licensee to ensure there was an emergency plan in place which provides for dealing with situations involving a missing resident. The homes written plan titled "Code Yellow – Missing Resident", policy number "XVII-D-10.30", dated May 2016, stated in part the following:

- The first person on the scene or designate will assume the role of Incident Commander and they will assess, begin code procedure, and call for assistance.
- The procedure for when a resident cannot be located includes searching all known/frequented areas of location/outside location. If the resident still cannot be located, the Incident Commander or designate will:
- Announce a code yellow.
- Organize a general search (internal/external). Team members familiar with resident should participate in the search.
- Call 911.
- Call family of resident and advise of situation.
- Check sign-out books and cameras to assist in determining when resident was last seen.
- Re-check the building and grounds and search as often as required (at least every shift)
- Keep the Executive Director/Administrator/General Manager notified.

A CIS report was submitted to the MOHLTC, related to an incident on an identified date when resident #015 was noted to be missing from the home.

A review of resident #015's progress notes in PCC showed multiple entries related to the incident by various registered staff.

A review of the home's investigation notes regarding the incident included email, hand written and typed written notes related to interviews and discussions with multiple staff members regarding the incident.

During an interview, DOC #101 reviewed resident #014's clinical record with Inspector #721. When asked what process the home would follow when a resident was noted to be missing, DOC #101 stated that staff would look for the resident and if they can't find the resident they would call a code yellow. DOC #101 told Inspector #721 that family and police would be notified when a resident was noted to be missing because sometimes family will take residents out and not

tell the home.

Therefore, the licensee failed to ensure that the home's emergency plan titled, "Code Yellow – Missing Resident" was followed for resident #015 when they were missing from the home.

3. In accordance with Ontario Regulation 79/10 114. (2), required the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Review of the home's policy titled "The Medication System- The Medication Pass" "Policy 3-6" stated that "each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route".

During observations on an identified date, the inspector identified that registered staff were administering medications to residents beyond the acceptable time period on multiple floors in the home. The inspector observed medications being prepared and administered to residents on a second identified date, at various times and locations beyond the acceptable time period.

During interviews, Registered Practical Nurse (RPN) #106 and #107 both verified that residents sometimes received their medication late because registered staff are pulled to complete other duties in the home. When asked how it is documented if a resident receives their medications late, RPN #106 stated that the electronic medication administration record (eMAR) stamps the time that the resident was administered their medications.

A review of resident #024's medication audit report for an identified date, documented multiple medications that were ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

A review of resident #013's medication audit report for the same identified date, documented one medication that was ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

Review of resident #006's medication audit report for the same identified date, documented multiple medications that were ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

During an interview with Director of Care (DOC) #101 when asked what the standard time frame in which medications are to be administered for the morning medication pass, DOC #101 stated that it would be administered within one hour on either side of the identified scheduled time. When asked if DOC #101 would expect that residents receive their ordered medications within this time frame, DOC #101 stated that it would be the expectation.

Review of resident #028's medication audit report for a previously identified date, documented multiple medications that were ordered to be administered at an identified scheduled date and time, were administered and documented late as indicated by the resident's eMAR.

During an interview with resident #028, when asked if they had received their medications late, resident #028 stated yes. When asked when resident #028 received their morning medications on an identified date, resident #028 stated that they received their medications including high risk medication late.

The licensee had failed to ensure that policy titled "The Medication System- The Medication Pass" "Policy 3-6" was complied with when resident #013, #024, #006, and #028 did not receive their prescribed medications at the correct times.

4. In accordance with Ontario Regulation 79/10 r. 136 (2), required the licensee to ensure the drug destruction and disposal policy must also provide for the following: That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

During an interview with Registered Nurse (RN) #105, when asked what the homes process was for the administration of an identified medication, RN #105 stated that the home had implemented a procedure which included discontinuing an identified medication from the resident on the evening shift, and the used identified medication was applied to a disposal sheet and the manager would come to collect the disposal sheet. RN #105 continued to state that each resident who used the identified medication had a disposal sheet which was kept in the

medication cart. RN #105 stated that pharmacy had told them that after discontinuing the used identified medication from the resident, the medication could be discarded into the medication disposal bin located in the medication room instead of applying to the disposal sheet.

Inspector requested RN #105 to see the disposal sheet that RN #105 was referring to. Inspector observed RN #105 unlock the medication cart and open the bottom drawer of the medication cart. Inspector observed and confirmed multiple pages of drug disposal sheets belonging to multiple residents, located in the same medication cart as other medications for administration to residents.

During an interview with Registered Practical Nurse (RPN) #106, they informed and showed the inspector that the used identified medications for disposal were kept in the medication cart with medications for administration to residents.

During an interview with RPN #107, they informed and showed the inspector that the used medication disposal sheets were also kept in the same location in the medication cart with other medications for administration to residents.

A review of the home's policy "Handling of Medication- 5-4- Drug Destruction and Disposal" stated "Store medications for destruction/disposal in a locked area in the medication room, separate from medications for administration to a resident. These medications should not be available to reuse."

During an interview with DOC #101, when asked where the used identified medications are kept, DOC #101 stated that they were to be kept on the drug disposal sheet. DOC #101 continued to state that each resident who was administered the identified medication had their own drug disposal sheet. When asked where those disposal sheets were stored, DOC #101 stated that the binder which contains the medication disposal sheets was supposed to be kept in the medication room. When asked if DOC #101 would expect that the medication disposal sheets be stored in a medication cart with drugs that were to be administered to residents, DOC #101 stated no. DOC #101 verified that medications for destruction was identified in the home's policy; and that the policy would not be followed if the used medication disposal sheets were kept in a drawer with medications that were to be administered to residents.

The licensee had failed to ensure that medication for disposal were placed in the designated location for destruction of medications as per the homes Drug

Destruction and Disposal policy.

Additional Required Actions:

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

(A1)
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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A CIS report was submitted to the MOHLTC on an identified date, related to resident #032 and allegation of staff to resident neglect.

Record review indicated that resident #032 was admitted to the home on an identified date, and received a cognitive assessment.

Record review of the CIS and progress notes indicated, and interviews with registered staff RPN #143 and PSW #144 verified that on an identified date and time, the PSW alerted the RPN to assess the resident's change in condition. The

RPN documented and reported the change in the resident's condition to the charge RN; then performed a full assessment and transferred the resident to hospital for further assessment and treatment.

During an interview, the DOC verified that PSWs documented inconsistently and did not report the change in findings to the registered staff working during their shift. However, the DOC also stated that PSWs documentation in POC should have been sent to the PCC Dashboard as an alert for the registered staff to review and cancel after reviewing the alerts at the end of their shift. Therefore, registered staff should have been aware of the change in condition; however, the PSWs did fail to mention the change in condition to registered staff. The DOC verified that the team did not collaborate or talk with each other related to the incident.

This finding was issued as a WN in this report based on a previous compliance order related to s. 6 which was compiled on June 10, 2019.

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented as provided to residents.

A CIS was submitted to the MOHLTC, related to an incident on an identified date, where resident #014 was missing for approximately one hour. The CIS report stated that after the incident a monitoring device was put in place to prevent recurrence.

A review of resident #014's Orders section in PointClickCare (PCC) included an identified medication order written by the physician with an identified start date. A review of resident #014's progress notes in PCC showed the sequence of events following the incident.

The resident's electronic Medication Administration Record (eMAR) and Treatment Administration Record (eTAR) in PCC were reviewed on identified dates, and they showed that the monitoring device was documented as "N/A" or missing on those identified dates.

During an interview, Registered Practical Nurse (RPN) #106 and RPN #108 stated if a resident had a monitoring device in place they would document that they checked the device on the resident's eMAR. RPN #106 stated that if a resident was missing their monitoring device they would document this as 'not

available' in the progress notes and on the resident's eMAR.

During an interview, Director of Care (DOC) #101 reviewed resident #014's clinical record with Inspector #721. When asked where staff would document if a resident had a monitoring device in place, DOC #101 stated that it was supposed to be on the resident's eTAR and staff would document on the eTAR that it was checked every shift. DOC #101 stated that if a resident was missing their monitoring device they would not expect this to be checked off as administered on their eTAR. DOC #101 reviewed resident #014's progress notes with Inspector #721, which identified that their monitoring device was "N/A" or missing on three identified dates and times. DOC #101 also reviewed resident #014's eTAR and verified that the order to check the monitoring device Q shift was documented as administered on those identified dates. When asked why it was documented on resident #014's eTAR that their monitoring device was in place on the identified dates and times when their progress notes identified the device to be N/A or missing, DOC #101 stated in part that they didn't know why staff signed on the eTAR that the monitoring device was in place and that they expected if the monitoring device was missing, it should have been documented on the eTAR as 'other'.

The licensee failed to ensure that when resident #014's monitoring device was missing for an identified period of time, that it was documented that this care was not provided.

3. The licensee has failed to ensure that the residents' plan of care was reviewed and revised when the resident's care needs changed.

A CIS report was submitted to the MOHLTC on an identified date and documented an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in health status.

The CIS report documented that a Personal Support Worker (PSW) reported to the charge nurse on an identified date, that when they were assisting resident #012, they noted that the resident displayed a change in health status. The report stated that the charge nurse assessed the resident and verified the change in status; and the Nurse Practitioner assessed the resident and sent them to hospital for further assessment and treatment.

Census was reviewed in Point Click Care (PCC) and showed resident #012's

status in the home over identified period of days. Progress notes in Point Click Care (PCC) were reviewed for resident #012 and showed their health status over a period of days since they returned to the home from hospital.

The Re-admission From Hospital Checklist for resident #012, on an identified date was reviewed and there was no documentation for "update eMAR/eTAR with new medication/treatment orders" completed when the resident had returned from hospital.

During an interview, the wound care lead (WCL)/ Registered Practical Nurse (RPN) #116 stated that when a resident returned to the home from hospital they would expect that their plan of care be updated. When asked how staff were made aware of interventions or treatments to be provided to a resident after they returned from hospital, the WCL/RPN stated that it would be documented in their discharge summary from the hospital. The WCL/RPN stated that the physician would be updated and then orders would be created. WCL/RPN #116 stated that treatments and interventions were based on the physician's orders and the nursing interventions were put into the eTAR. When asked where physician orders were documented, the WCL/RPN stated in the resident's chart. When asked if the resident had physician orders or treatments documented in their plan of care, the WCL/RPN stated no, there were no treatments in the eTAR and no physician orders were documented in PCC. WCL/RPN #116 stated that yes, they expected that resident #012's treatments should have had physician orders. When asked if they would expect that when the residents care needs changed that the information would be reflective in their plan of care, the WCL/RPN stated yes, it should have been.

The clinical records for resident #012 were reviewed in PCC and showed no documentation of physician orders or electronic treatment administration records (eTARs) related to the residents change in condition.

During an interview, the Assistant Director of Care (ADOC) #135 stated they reviewed the resident's chart and confirmed that there was no discharge summary provided when the resident had returned from hospital and no treatments or physician orders documented. When asked if they would expect that when the residents care needs changed, that they would be reassessed and that this information would be reflective in their plan of care, the ADOC stated yes.

The licensee has failed to ensure that resident #012's plan of care was reviewed

and revised when the resident's care needs changed after return from hospital.

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 provision of the care set out in the plan of care is documented as provided to residents; and
- to ensure that the residents' plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006's drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On an identified date and time, Inspector #507 observed identified medications for resident #027 on top of the chart rack located in the nursing station and left unattended.

In an interview, RPN #112 stated that they left the medication there after the medication administration because they had to go to the dining room. In interviews, RPN #112 and DOC #101 acknowledged that medication should be stored safely in the medication cart when not in use.

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A CIS report was first reported to the MOHLTC on an identified date, related to a medication incident for which resident #013 was transferred to hospital. The CIS report stated in part that on an identified date and time, resident #013 was noted to be experiencing negative symptoms. The report continues to state that the resident was assessed and 911 was called. Upon arrival to the home, paramedics noted the resident had two doses of medication administered instead of one.

A review of resident #013's medication orders on an identified date was completed and indicated that an identified medication was ordered for administration with specific instructions to discontinue the dose prior to the administration of the next dose.

A review of resident #013's eMAR over a period of days, documented that the order was "Hold/See Nurse Notes" or "Other/ See Nurse Notes" at both identified scheduled times on that date.

Review of the home's investigation notes included review of a Medication Incident Meeting held on an identified date, which identified that resident #013 was found to have two doses of the identified medication in place when they were only to have one. The meeting documentation continued to state that this medication incident suggested that the medication dose from the previous day was not discontinued or that the nurse administered the medication had incorrectly documented as the medication was on hold.

During an interview with DOC #101 when asked would you ever expect resident #013 to have two doses of the identified medication at any given time, DOC #101 stated no.

The licensee had failed to ensure that drugs were administered to resident #013 in accordance with the directions for use specified by the prescriber.

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 drugs are administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 was not neglected by staff.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

A CIS report was submitted to the MOHLTC, related to an incident which occurred on an identified date, where resident #015 was missing for approximately 12 hours.

A review of the CIS report indicated that resident #015 was sent unaccompanied to an appointment on an identified date to hospital; and was expected to return to the home in approximately four hours.

A review of resident #015's Documentation Survey Report v2 in PCC from an identified date and time, indicated that staff documented the resident was absent from the home or the activity did not occur as scheduled.

During an interview with RPN #106 and RPN #108, when asked what they would do if they noticed a resident was missing, they stated they would call the nurse manager and the residents Power of Attorney (POA), would call a code yellow and would go room to room in the whole building make sure they are not in any room.

A review of the home's investigation notes regarding the incident included emails, hand written notes and typed notes indicating staff interviews had occurred related to the incidents.

During an interview, Inspector #721 and DOC #101 discussed the incident where resident #015 was missing over a period of hours; and the DOC provided a sequence of event which occurred as per their investigation. DOC #101 told Inspector #721 that they would have expected staff to call a code yellow and go out on a limb to find out what happened when they first noted resident #015 to be missing on the night shift on that identified date, when they didn't return from their scheduled appointment. When asked if they considered the incident to be neglect, DOC #101 stated it was neglect; however the staff thought the resident was still in the hospital.

2. A CIS report was submitted to the MOHLTC on an identified date, related to an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in health status.

A review of the Point Click Care (PCC) Census showed resident #010's status indicated the resident was absent from the home for approximately seven days related to their injury.

A review of the Progress notes in Point Click Care (PCC) for resident #010 and showed that the resident experienced a symptom of their injury on multiple occasions during which an assessment and management of their symptom was not provided.

During an interview, Assistant Director of Care (ADOC) #135 stated that when a resident experience the identified symptoms an assessment would be initiated and referrals to the nurse manager or external consultants would be made as appropriate. The ADOC further stated that an assessment should have been

completed when a resident returned from hospital, when a resident was provided an intervention to determine effectiveness, and any other time a resident expressed or verbalized any related symptoms.

During an interview, Director of Care (DOC) #101 acknowledged that when resident #010 returned from hospital they did not receive an assessment related to their identified symptom. When asked if they would consider that staff failed to provide the resident with treatment, care or services required for health, safety and well-being based on inaction, the DOC stated yes. The DOC stated that yes, they would consider this to be neglectful of the resident's care needs.

3. The licensee has failed to ensure resident #034 was protected from abuse by PSW #102.

Ontario Regulations 79/10, s. 2 (1) (a) indicated emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that performed by anyone other than a resident.

A complaint and Critical Incident System (CIS) report was received by the Ministry of Long-Term Care on an identified date, related to resident #034.

Record review indicated resident #034 was admitted to the home on an identified date and assessed cognitively using the home's RAI-MDS assessment tool.

A review of the CIS and previous staff schedule roster indicated, and an interview with the resident and PSW #102 verified that on two identified dates, PSW #102 was assigned to provide care for resident #034 during the shift.

During an interview, resident #034 described their emotions felt while care was being provided during those shifts. During an interview, the resident's substitute decision maker (SDM) informed the inspector that they visited the resident daily and verified a change in the resident's status during the visit following those shifts. The resident's status prompted them to report the incident to the ADOC and prompted an investigation.

During an interview, PSW #102 verified they were assigned to provide care and verified some statements made by the resident but denied other statements

related to the incident.

During separate interviews, the resident's primary PSWs informed the inspector that the resident was credible; and PSW #101 verified pieces of information which supported the resident's report of the incident.

During an interview, ADOC #107 informed the inspector that they were helping to support another ADOC during the incident; but recalled that during the interview, resident #034 was adamant that PSW #102 provided inappropriate care to the resident.

During separate interviews, registered staff RN #108 stated the resident was reliable; and that they never had an incident when the resident did not tell the truth. RN #108 and PSW #109 informed the inspector if the resident stated something happened, they would believe that the incident occurred because the resident never complains.

During an interview, the home's DOC acknowledged that the investigation should have been more thorough and stated that more interviews should have been conducted. The DOC also verified that there were inconsistencies encountered during the investigation, but if the incident occurred, the PSW's actions would be considered abuse of resident #034.
THIS FINDING WAS INCLUDED AS SUPPORTING EVIDENCE FROM INSPECTION #2019_808535_0011.

This finding was issued as a WN in this report based on a compliance order related to s. 19 (1) which was complied on June 6, 2019. [s. 19. (1)]

WN #6: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report was made to the Director with the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Specifically, the licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported to the licensee, was immediately investigated and appropriate action was taken in response to every such incident and reported to the Director.

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an allegation of witnessed abuse of resident #025. The CIS report stated in part that resident #029 had reported to the Director of Care (DOC) and the Executive Director (ED) that they had witnessed staff member #134's interactions with another resident #025.

During the review of the CIS report, it was identified that the initial investigation was initiated and resident #025 was assessed, however the report did not identify the outcome of the investigation.

During an interview with DOC #101, when asked who completes amendments for CIS reports, DOC #101 stated that management completes amendments. Review of resident #025's progress note on an identified date, stated in part, that the DOC and ED had received a report regarding an incident that occurred; and that the family had been notified that an investigation was initiated and voiced no concerns.

During an interview with Quality and Informatics Partner (QIP) #113 when asked what their expectation was if staff were to see or suspect abuse in the home, QIP #113 stated that they would expect that staff complete their reporting requirements and that management would complete an investigation.

Review of the homes policy in place at the time of the incident titled "Prevention of Abuse & Neglect of a Resident VII-G-10.00" stated in part, that the ED or designate was to initiate the investigation by requesting that anyone aware or involved in the situation to write, sign, and date a statement accurately describing the event. This policy continued to state, "All investigative information is kept in a separate report from the residents record".

After multiple requests for investigation notes and information regarding the outcome of investigation over a period of five days regarding the CIS report, QIP #113 and management were unable to provide this information to inspector.

2. A) A CIS report was submitted to the MOHLTC, related to allegations of staff abuse towards resident #023 on an identified date. The CIS report was not amended to report the outcome of the investigation into these allegations of physical abuse.

Inspector #721 requested documentation on the home's investigation into the incident from Quality & Informatics Partner #112. The home was unable to provide any documentation related to their investigation.

During an interview, DOC #101 discussed the CIS report and reviewed resident #023's clinical record with Inspector #721. When asked what the homes process was for investigating allegations of abuse, DOC #101 stated they would get a statement from the alleged abuser, interview the alleged abuser, and keep a documented record of the investigation. DOC #101 stated they would update the MOHLTC regarding the outcome of investigations into allegations of abuse as they investigate. When asked if they had a documented record of the home's investigation into this allegation of abuse, DOC #101 stated they didn't have the documented record. DOC #101 verified that the CIS report was not amended to provide the Director with the results of the investigation.

B) A CIS report was submitted to the MOHLTC, related to allegations of staff abuse towards resident #023 on an identified date. The CIS report was not amended to report the outcome of the investigation into these allegations of verbal and emotional abuse.

Inspector #721 requested documentation on the home's investigation into the incident from Quality & Informatics Partner #112. The home was unable to

provide any documentation related to their investigation.

During an interview, DOC #101 discussed the CIS report and reviewed resident #023's clinical record with Inspector #721. When asked if they had a documented record of the home's investigation into the allegations of abuse reported in this CIS report, DOC #101 stated they were unable to find a documented record. DOC #101 verified that the CIS report was not amended to provide the Director with the outcome of the investigation.

C) A CIS report was submitted to the MOHLTC, related to allegations of staff abuse towards resident #023 on an identified date. The CIS report was not amended to report the outcome of the investigation into these allegations of physical abuse.

Inspector #721 requested documentation on the homes investigation into the incident reported in the CIS report from Quality & Informatics Partner #112. The home was unable to provide any documentation related to their investigation.

During an interview, DOC #101 discussed the report and reviewed resident #023's clinical record with Inspector #721. When asked if they had a documented record of the home's investigation into the allegations of abuse reported in the CIS report, DOC #101 stated they were unable to find a documented record. DOC #101 verified that the CIS report was not amended to provide the Director with the results of the investigation.

3. A CIS report was submitted to the MOHLTC on an identified date, regarding a neglect allegation of resident #026. The home completed a review of the care and interventions the resident received in the home during their stay between an identified period.

Further review of the CIS report did not identify an amendment that included the outcome of the investigation. This was acknowledged by ED #100 during an interview.

4. A CIS report was submitted to the MOHLTC on an identified date, related to resident #031, and an allegation of staff to resident abuse.

Record review of the CIS indicated that the outcome of the investigations and the resident's current health status were not included. Furthermore, the home did not submit an amended report to the Director, as verified by the home's DOC during an interview.

5. A CIS report was submitted to the MOHLTC on an identified date, related to resident #032, and an allegation of staff to resident neglect.

Record review of the CIS indicated that the outcome of the investigations and the resident's current health status were not included. Furthermore, the home did not submit an amended report to the Director, as verified by the home's DOC during an interview.

This finding was issued as a WN in this report based on a s. 23 compliance order which was complied on June 10, 2019. [s. 23. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the abuse of residents by staff that resulted in harm or a risk of harm to the residents was reported to the Director immediately.

A CIS report was submitted to the MOHLTC on an identified date, regarding an abuse allegation towards multiple residents.

Review of the CIS report indicated that the home received information on an identified date, regarding allegations of resident abuse involved four residents and two staff members.

In an interview, ED #100 acknowledged the above mentioned abuse allegation was not reported to the Director immediately as required under the LTCHA.

2. A CIS report was submitted to the MOHLTC on an identified, regarding staff to resident abuse.

A review of the CIS and progress notes indicated that the incident occurred on an identified date; however, the home reported the incident to the Director on a later identified date. During an interview, the DOC verified that the incident of alleged abuse should have been reported by the home immediately.

WN #8: 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,
(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;
O. Reg. 79/10, s. 50 (2).

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 a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A CIS report was submitted to the MOHLTC on an identified date, regarding an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

The CIS report documented that a Personal Support Worker (PSW) reported to a Registered Practical Nurse (RPN) on an identified date, that resident #011 was experiencing an identified symptom; and the resident's roommate verified the same. As per the report, the charge nurse assessed the resident, call the physician and the resident was transferred to hospital for further assessment. The

resident returned to the home with no change in treatment.

The clinical records of resident #011 were reviewed and there was no documentation of a head to toe assessment being completed when the resident returned from a hospital absence of greater than 24-hour.

During an interview, Wound Care Lead (WCL)/Registered Practical Nurse (RPN) #116 stated that they were familiar with resident #011. WCL/RPN #116 reviewed the residents' clinical records in PCC stated that resident #011 had returned from hospital and verified that the head to toe assessment was not completed in PCC on the day they had returned. When asked if they would expect that the resident had received a skin assessment (head to toe assessment) on the day they had returned from hospital, the WCL/RPN stated yes.

The Re-admission From Hospital Checklist with an identified date was reviewed for resident #001; and there was no documentation that a skin assessment (head to toe assessment) was completed when the resident had returned from hospital.

During an interview, Director of Care (DOC) #101 stated that resident #011 returned to the home from hospital with a diagnosis. The DOC reviewed the resident's clinical records. When asked if they would expect that skin assessment (head to toe assessment) had been completed when the resident had returned from hospital, the DOC stated yes there should have been a completed assessment.

2. A CIS report was submitted to the MOHLTC on an identified date, related to an incident that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

Record review indicated that on an identified date, the home received a call from the diagnostic imaging services which indicated that resident #010's sustained an identified injury; and the resident was sent to hospital for assessment and treatment.

A review of the Point Click Care (PCC) Census showed resident #010's was absent from the home for an identified number of days related to the injury.

The clinical records of resident #010 were reviewed and there was no

documentation of a skin assessment (head to toe assessment) being completed when the resident returned to the home.

During an interview, Wound Care Lead (WCL)/Registered Practical Nurse (RPN) #116 stated that when a resident returned from hospital the registered staff should complete standard assessments for a new admission, including a skin and wound assessment, head to toe assessment and pain assessment; that if there were any compromised skin integrity issues, then the staff should complete another skin assessment for that specific area; and that assessments were documented under the Assessments section in PCC.

When asked what the expectation was for assessing the residents' skin upon return to the home from hospitalization, the WCL/RPN stated that they should be assessed within 24 hours by a nurse on the floor. The WCL/RPN stated that they were familiar with resident #010. When asked if resident #010 received a skin assessment upon their return from hospital, the WCL/RPN stated that they did not see any assessments completed for the resident when they had returned from hospital. The WCL/RPN stated that the assessments, including skin and wound and head to toe, should have been completed for resident #010.

During an interview, Director of Care (DOC) #101 stated that no assessments were completed for resident #010 when they returned from hospital; and that they expected that a skin and wound assessment should have been completed.

3. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A CIS report was submitted to the MOHLTC on an identified date, regarding an incident that caused an injury.

Progress notes were reviewed in Point Click Care (PCC) and showed a note which stated that resident #010's had a procedure completed while in hospital.

A skin observation note from an identified date noted concerns related to altered skin integrity of an identified body part for the resident post hospitalization.

Electronic Treatment Administration Records (eTARs) from PCC for an identified period were reviewed for resident #010 and showed that there were physician treatment orders written related to providing care to those areas.

Assessments were reviewed in PCC for resident #010 and there were no documented initial or weekly assessments completed related to altered skin integrity to a specific body area after the resident returned from hospital.

During an interview, Wound Care Lead (WCL)/Registered Practical Nurse (RPN) #116 stated that resident #010's should have had weekly assessments completed during the period after their return from hospital.

During an interview, Assistant Director of Care (ADOC) #135 reviewed resident #010's clinical records in PCC and stated that they would expect that an assessment should have been completed weekly for resident #010 related to their altered skin integrity.

During an interview, Director of Care (DOC) #101 acknowledged that when resident #010 returned from hospital weekly assessments were not completed.

4. The licensee has failed to ensure that when resident #010 had exhibited altered skin integrity, including pressure injuries, the resident had received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A CIS report was submitted to the MOHLTC on an identified date, related to an incident that caused an injury to a resident for which the resident was taken to hospital.

The Documentation Survey Report V2 was reviewed in PCC for resident #010 and showed documentation related to altered skin integrity on identified dates. During an interview, Wound Care Lead (WCL)/Registered Practical Nurse (RPN) #116 stated that when a Personal Support Worker (PSW) identified a new area of compromised skin integrity they would expect that the staff inform the nurse immediately; and, if registered staff did not take care of the identified area right away, the altered skin integrity could get worse.

Inspector #689 and WCL/RPN #116 reviewed the documentation records for resident #010 and the WCL/RPN stated that there was documentation that the resident first showed altered skin integrity on an identified date.
- When asked if they would expect that altered skin integrity that were identified for this resident on the initial date had been communicated to the nurse, the WCL/RPN stated of course.
- When asked when the information about the resident's altered skin integrity were first assessed by the nurse, the WCL/RPN stated not until a later date, based on when they had received the referral.
- The WCL/RPN verified that they found out about the resident's altered skin integrity on a later date; and stated that if the nurse had done the skin and wound assessment on the initial day when the resident returned from hospital it could have been captured.
- When asked if they would expect that the resident's altered skin integrity had been assessed when first identified on the initial date, the WCL/RPN stated yes.

During an interview, Assistant Director of Care (ADOC) #135 reviewed resident #010's clinical records and acknowledged that the resident exhibited altered areas of skin integrity on the initial identified date but was not assessed until a later date. The ADOC stated that they would expect that the resident should have been assessed and provided immediate treatment.

5. The licensee has failed to ensure that resident #026 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A CIS report was submitted to the MOHLTC on an identified date, regarding allegation of neglect related to resident #026.

Review of resident #026's progress notes indicated that the resident was admitted to the home with identified diagnosis. The resident was sent to the hospital on another identified date and was treated for an acute diagnosis.

Review of the progress notes indicated that referrals were made to the Registered Dietitian (RD) for nutritional assessment on another identified date. Review of the Point Click Care (PCC) electronic record indicated there was no nutritional

assessment completed by the RD between an identified period. This was confirmed by the RD #139 during an interview.

This finding will be issued as a WN in this report based upon information inspected prior to the due date of compliance order #004 with due date June 10, 2019.

WN #9: 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 retrained by the licensee for at least 10 years after the resident was discharged from the home.

A CIS report was submitted to the MOHLTC on an identified date, related to resident #032, and an allegation of staff to resident neglect.

A review of the CIS report and electronic progress notes indicated that the resident was transferred to hospital on an identified date related to an incident which caused a change in the resident's health status; and passed away shortly afterwards on a later date.

The inspector requested the resident's archived paper chart for review; and was informed by the DOC and Quality & Informatics Partner that the resident's chart could not be found during the period of the onsite inspection.

Therefore, the home failed to ensure that the record of every former resident of the home was retrained by the licensee for at least 10 years after the resident was discharged from the home.

Issued on this 7 th day of November, 2019 (A1)

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

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by VERON ASH (535) - (A1)
Inspection No. / No de l'inspection :	2019_808535_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009132-17, 024790-17, 003801-18, 004733-18, 005254-18, 015839-18, 020577-18, 025946-18, 026115-18, 029054-18, 029840-18, 030261-18, 030343-18, 031204-18, 031629-18, 000989-19, 002755-19, 003251-19, 006365-19, 006366-19, 006367-19, 006368-19, 006369-19, 006370-19, 009563-19, 010289-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 07, 2019(A1)
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 :	Roxanne Adams

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:

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. 8. Policies, etc., to be followed, and records

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).

Specifically, the licensee shall conduct the following:

1. Remove mouldy or water stained drywall in the dried goods storage room and replace with new drywall, patch and seal. Remove peeling wallpaper from a section of wall in the identified floor dining room under the main windows, clean the visible mould and paint with mould resistant paint.

2. All flooring material that has lifted in resident washrooms shall be made smooth and tight-fitting. Repair the floor gouge in the identified floor dining room so that the floor is even and smooth.

3. Replace or remove the damaged over bed table on the identified floor and in the identified resident room.

4. All door hinges that produce disturbing sounds shall be lubricated.

5. Rusty table bases shall be resurfaced so that they are free of rust, smooth and easy to clean.

6. All drains shall be inspected and cleaned out where necessary to prevent insect breeding and to ensure traps are full and that drains are in good condition.

7. Warped, rotted and water damaged shelving shall be removed from under all identified floors dining room utility sinks.

8. Complete an audit of all windows (frames, sills, glass, screens, hardware), interior doors (surfaces, hardware/hinges), hand rails, flooring and furnishings in the home to determine level of condition. Document results, date of audit and follow up action (date work completed or any proposed dates for completion) and person responsible and have available for inspection upon follow-up.

9. Provide training related to the home's Code Yellow Policy to all registered staff; and document proof of training by way of an attendance list.

10. Within two weeks of receiving this compliance order, develop and implement a plan/protocol to ensure residents who are absent from the home for appointments or leave of absence are tracked and securely located at the end of their period of absence. Otherwise, registered staff must verify and document a valid reason for the resident's continued absence from the home. Please document the plan/protocol with the most responsible person listed for review upon request.

11. Within two weeks of receiving this compliance order, develop and implement a plan/protocol to ensure all drugs that are discontinued or for destruction/disposal are stored safely and securely in the home, and separately from drugs that are available for administration to residents. Please document the plan/protocol with the most responsible person listed for review upon request.

12. Within one month of receiving this compliance order, develop and implement a plan/protocol to ensure residents prescribed medications are administered in keeping with best practice and in a timely manner, particularly related to residents #024 and #028; and all other residents as applicable in the home. Please document the plan/protocol with the most responsible person listed for review upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee was required to ensure that the procedure was complied

with.

In accordance with O. Reg. 79/10, 90(1)(b), the licensee was required to have in place, procedures and schedules for routine, remedial and preventive maintenance. Confirmation was made that procedures and schedules for preventive maintenance were in place, but they were not complied with.

The following observations were made at the time of inspection:

1. Window glass in three dining rooms were cracked. According to the Building Services Partner, windows were not on the capital plan for replacement in 2019.

2. Wood trim on windows located at corridor ends and in dining rooms and resident rooms were peeling and some had dry rot. There was no plan in place to address this concern.

3. Wood hand rails in corridors on all floors were not in good condition as they were gouged and worn. No plans were in place to address this concern.

4. Tubs were not maintained in good operating order. Three tub models were not mechanical and were positioned directly on the floor. No water supply to the faucets was provided when they were turned on. Three tub models were designed with a door on the side of the tub for entry and exit. All three had articles inside of the tubs and two were identified to have broken parts and were not functional. One tub model, which was mechanical and very long, had broken parts and was not functional. No paperwork could be provided from 2018 that the tubs were inspected by the tub company. Seven out of the ten tubs were inspected on an identified date, after their condition was raised with the Executive Director. The other three tub models (non-mechanical) were not purchased from the same tub company, and the technician did not check them. No records could be provided by the DES that the tubs were inspected as per the homes procedures and schedule (monthly).

5. Bathroom vinyl sheet flooring lifted and rippled in but not limited to two identified resident washrooms. Many others had split seams under the bathroom vanities and the edges were lifting in two identified bathrooms. The DES was unaware of the condition.

6. Warped and rotted shelving under utility sinks in three identified floor dining rooms from water leaking. The DES was unaware of their condition.

7. Mouldy and water stained dry wall section (approx. 3 feet by 3 feet) located in the dried goods storage room. By end of day, the same area was covered over with a vinyl sheet instead of having the damaged drywall removed and replaced.

8. Over bed table was observed to be in use by resident in the corridor. It was missing a large section (6 cm by 6 cm) in one corner and was rough. An over bed table in a resident room was also in poor condition.

9. Door hinges on multiple bathroom doors in resident rooms on but not limited to a specific floor were very noisy.

10. A deep triangular shaped gouge approx. 10 cm x 5 cm was noted in the PVC floor tile on an identified floor in the dining room. The depression presented a hazard for tripping. The DES was unaware of the condition and was shown the area on an identified date.

11. Table bases in some of the dining rooms were rusted.

12. A section of wall paper in the dining room on the third floor (under a window) had peeled back and exposed some minor mould growth on the drywall. The DES was under the impression that they were not allowed to deal with mouldy surfaces. The DES was informed that any area of mould below ten square feet in size can be cleaned and managed by maintenance staff without any special qualifications.

13. Fruit flies were noted to be in excess inside of the main kitchen. The fruit flies were of a species that breed in drains and wet, damp areas (as opposed to within fruit). The Food Services Supervisor was not aware when and if the floor drains were ever cleaned. The task was under the maintenance department. According to the home's preventive maintenance schedule, floor drains were required to be checked or cleaned once per month. When access was provided to the home's electronic system of record keeping, no notations or evidence was available to indicate when or if someone conducted the task.
THIS FINDING WAS INCLUDED AS SUPPORTING EVIDENCE FROM INSPECTION #2019_539120_0022. (535)

2. In accordance with Ontario Regulation 79/10, s. 230, required the licensee to ensure there was an emergency plan in place which provides for dealing with situations involving a missing resident. The homes written plan titled "Code Yellow – Missing Resident", policy number "XVII-D-10.30", dated May 2016, stated in part the following:

- The first person on the scene or designate will assume the role of Incident Commander and they will assess, begin code procedure, and call for assistance.
- The procedure for when a resident cannot be located includes searching all known/frequented areas of location/outside location. If the resident still cannot be located, the Incident Commander or designate will:
- Announce a code yellow.
- Organize a general search (internal/external). Team members familiar with resident should participate in the search.
- Call 911.
- Call family of resident and advise of situation.
- Check sign-out books and cameras to assist in determining when resident was last seen.
- Re-check the building and grounds and search as often as required (at least every shift)
- Keep the Executive Director/Administrator/General Manager notified.

A CIS report was submitted to the MOHLTC, related to an incident on an identified date when resident #015 was noted to be missing from the home.

A review of resident #015's progress notes in PCC showed multiple entries related to the incident by various registered staff.

A review of the home's investigation notes regarding the incident included email, hand written and typed written notes related to interviews and discussions with multiple staff members regarding the incident.

During an interview, DOC #101 reviewed resident #014's clinical record with Inspector #721. When asked what process the home would follow when a resident was noted to be missing, DOC #101 stated that staff would look for the resident and if they can't find the resident they would call a code yellow. DOC #101 told Inspector #721 that family and police would be notified when a resident was noted to be

missing because sometimes family will take residents out and not tell the home.

Therefore, the licensee failed to ensure that the home's emergency plan titled, "Code Yellow – Missing Resident" was followed for resident #015 when they were missing from the home. (721)

3. In accordance with Ontario Regulation 79/10, s. 114. (2), required the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Review of the home's policy titled "The Medication System- The Medication Pass" "Policy 3-6" stated that "each resident receives the correct medication in the correct prescribed dosage, at the correct time, and by the correct route".

During observations on an identified date, the inspector identified that registered staff were administering medications to residents beyond the acceptable time period on multiple floors in the home. The inspector observed medications being prepared and administered to residents on a second identified date, at various times and locations beyond the acceptable time period.

During interviews, Registered Practical Nurse (RPN) #106 and #107 both verified that residents sometimes received their medication late because registered staff are pulled to complete other duties in the home. When asked how it is documented if a resident receives their medications late, RPN #106 stated that the electronic medication administration record (eMAR) stamps the time that the resident was administered their medications.

A review of resident #024's medication audit report for an identified date, documented multiple medications that were ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

A review of resident #013's medication audit report for the same identified date, documented one medication that was ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

Review of resident #006's medication audit report for the same identified date,

documented multiple medications that were ordered to be administered at a scheduled time on that date was administered late as time stamped by the resident's eMAR.

During an interview with Director of Care (DOC) #101 when asked what the standard time frame in which medications are to be administered for the morning medication pass, DOC #101 stated that it would be administered within one hour on either side of the identified scheduled time. When asked if DOC #101 would expect that residents receive their ordered medications within this time frame, DOC #101 stated that it would be the expectation.

Review of resident #028's medication audit report for a previously identified date, documented multiple medications that were ordered to be administered at an identified scheduled date and time, were administered and documented late as indicated by the resident's eMAR.

During an interview with resident #028, when asked if they had received their medications late, resident #028 stated yes. When asked when resident #028 received their morning medications on an identified date, resident #028 stated that they received their medications including high risk medication late.

The licensee had failed to ensure that policy titled “The Medication System- The Medication Pass” “Policy 3-6” was complied with when resident #013, #024, #006, and #028 did not receive their prescribed medications at the correct times.

(535)

4. In accordance with Ontario Regulation 79/10, s. 136 (2), required the licensee to ensure drug the destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

During an interview with Registered Nurse (RN) #105, when asked what the homes process was for the administration of an identified medication, RN #105 stated that the home had implemented a procedure which included discontinuing an identified medication from the resident on the evening shift, and the used identified medication was applied to a disposal sheet and the manager would come to collect the disposal

sheet. RN #105 continued to state that each resident who used the identified medication had a disposal sheet which was kept in the medication cart. RN #105 stated that pharmacy had told them that after discontinuing the used identified medication from the resident, the medication could be discarded into the medication disposal bin located in the medication room instead of applying to the disposal sheet.

Inspector requested RN #105 to see the disposal sheet that RN #105 was referring to. Inspector observed RN #105 unlock the medication cart and open the bottom drawer of the medication cart. Inspector observed and confirmed multiple pages of drug disposal sheets belonging to multiple residents, located in the same medication cart as other medications for administration to residents.

During an interview with Registered Practical Nurse (RPN) #106, they informed and showed the inspector that the used identified medications for disposal were kept in the medication cart with medications for administration to residents.

During an interview with RPN #107, they informed and showed the inspector that the used medication disposal sheets were also kept in the same location in the medication cart with other medications for administration to residents.

A review of the home's policy "Handling of Medication- 5-4- Drug Destruction and Disposal" stated "Store medications for destruction/disposal in a locked area in the medication room, separate from medications for administration to a resident. These medications should not be available to reuse."

During an interview with DOC #101, when asked where the used identified medications are kept, DOC #101 stated that they were to be kept on the drug disposal sheet. DOC #101 continued to state that each resident who was administered the identified medication had their own drug disposal sheet. When asked where those disposal sheets were stored, DOC #101 stated that the binder which contains the medication disposal sheets was supposed to be kept in the medication room. When asked if DOC #101 would expect that the medication disposal sheets be stored in a medication cart with drugs that were to be administered to residents, DOC #101 stated no. DOC #101 verified that medications for destruction was identified in the home's policy; and that the policy would not be followed if the used medication disposal sheets were kept in a drawer with

medications that were to be administered to residents.

The licensee had failed to ensure that medication for disposal were placed in the designated location for destruction of medications as per the homes Drug Destruction and Disposal policy.

The severity of this issue was determined as actual harm/risk to the resident. The scope of the issue was patterned. The licensee had previous findings of non-compliance with this section of the Ontario Regulations which included: Inspection #2018_626501_0021, December 2018, a Written Notification was issued; #2017_644507_0003, May 2017, a Voluntary Plan of Corrections was issued; #2016_353589_0016, December 2016, a Voluntary Plan of Corrections was issued; #2016-377502-0011, August 2016, a Written Notification was issued. As such, a Compliance Order is warranted. (435)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2020(A1)

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 7 th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by VERON ASH (535) - (A1)

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

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