Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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

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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2020	2019_780699_0024 (A1)	019835-18, 026393-18, 008815-19, 012751-19, 014326-19, 014792-19, 015239-19, 016725-19, 019507-19, 020170-19, 021496-19, 022259-19	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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #001 and #002 due date has been changed to July 31, 2020.

Issued on this 22nd day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by PRAVEENA SITTAMPALAM (699) - (A1)

Amended 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): November 19-22, 25-29, December 2-6, 9-11, 2019.

The following complaint intakes were inspected during this inspection:

-log #026393-18 - related to dining;

-log #012751-19 - related to infection control;

-log #019835-18 - related to assessments, plan of care;

-log #021496-19 - related to resident rights, showers not provided;

-log #020170-19 - related to responsive behaviours, resident rights;

-log #016725-19, 015239-19, 022259-19 - related to alleged resident abuse;

-log #014792-19 - related to skin and wound, odours in the home, missing laundry; and

-log #008815-19, 014326-19 - related to housekeeping, responsive behaviour, infection control.

The following Critical Incident System (CIS) intake related to the same issue (alleged abuse) were completed during this Complaint inspection:

-log #019507-19, CIS 2789-000104-19 related to staff to resident abuse.

A Compliance Order (CO) under LTCHA, 2007, c.8, s. 6 (7), identified in this inspection (Log #019507-19, 022259-19) will be issued under Critical Incident inspection 2019_780699_0025 concurrently inspected during this inspection.

A VPC under LTCHA, 2007, s. 23 (1)(a), identified in this inspection (log #019507-19, 022259-19) will be issued under Critical Incident inspection 2019_780699_0025 concurrently inspected during this inspection.

A Written Notification (WN) under LTCHA, 2007, s. 24 (1), identified in this inspection (log #019507-19, 022259-19) will be issued under Critical Incident inspection 2019_780699_0025 concurrently inspected during this inspection.

A WN under O.Reg 79/10, r. 8 (1)(b), identified in this inspection (log #014792-19) will be issued under Critical Incident inspection 2019_780699_0025 concurrently inspected during this inspection.

A VPC under O.Reg 79/10, r. 50 (2) (b) (iv), identified in concurrent inspection 2019_780699_0025 (log #020570-19) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Interim ED, Director of Care (DOC), Assistant Director of Care (ADOC); and Nurse managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietician (RD), Director of Environmental Services (ES), Personal Support Workers (PSW),dietary aides, laundry aides, residents, substitute decision makers (SDM), and family members.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of care, reviewed resident health records, staff training

records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **13 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity including skin breakdown: (i) received 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 and (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A complaint was received by the Director regarding the alleged incident of abuse and neglect of resident #012. The complaint stated that the resident had altered skin integrity on a specific area of their body.

The home's policy titled, "Skin and Wound Care Program Management, #VII-G-10.80", revised on April 2019, directed registered staff members to conduct a head to toe and skin assessments, when a resident has altered skin conditions such as skin tear and bruises. The policy also directed staff members to initiate treatments immediately, to promote healing and prevent infection.

Record review of the progress notes indicated that resident #012 had a fall on a specific date and sustained an altered skin integrity on an identified part of their body. The notes indicated that the initial skin and head to toe assessments were not completed following the fall. There was no treatment initiated. The records

indicated that RN #114 completed the initial skin and head to toe assessment five days after the incident.

Interview with RN #114 confirmed that there was no initial skin and head to toe assessments completed following the fall incident. They indicated that they completed the required assessment and initiated treatments, five days after the fall. RN #114 reiterated that it was the expectation of the home to complete a head to toe and skin assessments immediately after a resident has altered skin conditions, initiate treatments and document the findings.

Interview with the DOC indicated that it was the home's expectation that registered staff complete skin assessments using the home's skin assessment tool when a resident has altered skin conditions and initiate treatments. They confirmed that the registered staff did not use the assessment tool, initiate treatments and document findings as expected. [s. 50. (2) (b)]

2. The licensee has failed to ensure that resident #034's altered skin integrity received 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.

The Director received a complaint from resident #034's SDM in regards to an abuse investigation conducted by the home.

During a conversation, resident #034's SDM expressed their concerns related to the resident's altered skin integrity of unknown cause to the inspector. On November 28, 2019, the inspector received an email from resident #034's SDM. The email contained 20 images of altered skin integrity on different locations of the body between a specific time period.

Review of the home's "Skin & Wound Care Management Protocol" policy #:VII-G-10.90 (page 3), indicated when a resident is experiencing intact skin alterations, i.e. excoriation, rashes, bruises, staff are to complete an electronic head to toe Assessment weekly until healed.

Review of resident #034's progress notes, assessments and the images provided by resident #034's SDM, indicated a skin assessment had not been completed by a registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for two identified altered

skin integrity on two separate dates.

In an interview, ADOC #134 stated a head to toe assessment should be completed by registered staff for any altered skin integrity. ADOC #134 acknowledged there was no documentation in the progress notes regarding the above mentioned altered skin integrity, and there was no skin assessment completed for the altered skin integrity as required. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that resident #034, #003 and #025's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a. Review of resident #034's progress notes indicated an altered skin integrity was observed on a specific date. Review of the skin and wound care assessments indicated the skin and wound assessment had not been completed on two separate dates.

Review of resident #034's progress notes indicated an altered skin integrity on a different identified area was observed on a specific date. Review of the treatment administration record (TAR) for an identified month indicated an order for an identified altered skin integrity. Review of the weekly skin and wound care assessments indicated the skin and wound care assessments had not been completed for the identified altered skin integrity on six separate dates.

In an interview, ADOC #134 stated a head to toe assessment should be completed by registered staff for any altered skin integrity. A skin and wound care assessment should be completed for any open altered skin integrity, such as skin tear, pressure ulcer or wound. The skin and wound care assessment should be completed weekly until healed. ADOC, #134 acknowledged the above mentioned skin and wound assessments were not completed as required.

b. The Director received a complaint related to resident #003's altered skin integrity.

Record review indicated that resident #003 was admitted to the home and was assessed using the home care assessment tool prior to their admission which indicated no skin condition. The home's quarterly RAI-MDS assessment on a later date, indicated different altered skin integrity with skin treatment.

Record review of the progress notes indicated the resident started getting altered skin integrity on a specific area of their body in a specific month. This information was verified during separate interviews by the resident's substitute decision-maker (SDM) #169 who attended the home daily, and registered staff RPN #108. Further review of the progress notes indicated that resident #003 continued to be seen by the physician a month later for their altered skin integrity.

Record review of the resident's skin assessment records indicated there were few documented skin assessments to be located. The inspector requested the home's Skin and Wound Care Lead #174 to locate the resident's weekly skin assessments documentation for the period of when the altered skin integrity began until it resolved.

On December 10, 2019, weekly head to toe assessments related to the above mentioned altered skin integrity were presented to the inspector by the Skin and Wound Care lead #174. However, there were no weekly completed head to toe assessments for the identified altered skin integrity for two specific months.

During an interview, the Skin and Wound Care Lead verified that residents with altered skin integrity should receive a documented weekly skin assessment to assess the status of the skin and ensure current treatment is successful or whether a reassessment is required. Therefore, the home failed to ensure resident #003's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

c. The Director received a critical incident system (CIS) report related to resident to resident abuse. Review of the CIS showed that an altercation between resident #026 and resident #025 occurred.

Record review of resident #025's progress notes indicated that the resident sustained specific altered skin integrity to a specific area of their body as result of a resident to resident altercation. Further review of the progress notes indicated that on a specific date, the altered skin integrities were still visible. The progress notes did not indicate when they healed.

Review of resident #025's initial skin assessment on the day of the altercation showed several areas of altered skin integrity to specific areas of their body.

Record review of the assessments in pointclickcare (PCC) did not reveal any

weekly skin assessments completed for the resident's altered skin integrity.

Review of the home's "Skin & Wound Care Management Protocol" policy #:VII-G-10.90 (page 2), indicated when a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, staff to:
- Initiate and complete electronic weekly skin and wound assessment.

In an interview with RPN#116, they indicated that weekly skin assessments should be completed utilizing the skin assessment form. They further stated that a weekly skin assessment should have been completed for resident #025. [s. 50. (2) (b) (iv)]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff participated in the implementation of the infection prevention and control program.

The MLTC received a complaint related to the home's infection control practice.

Record review of the home's infection control and outbreaks documentation indicated that on a specific date, the home reported respiratory outbreak to the Ministry of Long-Term Care and Public Health agency. A review of the home's outbreak records, including residents and staff line listing, indicated that a specific number of residents and staff member were experiencing respiratory symptoms prior to the report of an outbreak to the above mentioned authorities.

Record review of the Toronto Public Health (TPH) summary letter addressed to the home confirmed the following:
"The home experienced a respiratory outbreak during an identified period. During this period, restrictions were placed on admission and re-admission to the affected units – the outbreak was for the 'entire facility'. Two identified strains were indicated as the causative agents for this outbreak. Toronto Public Health recommends the following in order to improve outbreak management in the home: Educate staff about Outbreak Detection (Surveillance) and Outbreak Reporting Requirements".

The letter continued to say: "Timely reporting of outbreaks (including week nights and week-ends) is also an essential component of outbreak (OB) management as per the Health Protection and Promotion Act, R.S.O. 1990 c. H. 7, O. Reg. 135/18".

TPH was notified about this outbreak on a specific date at which an identified number of residents from an identified floor were experiencing acute respiratory symptoms. As indicated on the line list, the earliest onset dates were on several days prior to when TPH was notified. As per the TPH letter, had TPH been notified on that date a respiratory outbreak would have been declared and infection prevention and control measures, specimen collection and testing could have been implemented in a timely manner. Specimen results and addition preventative interventions (such as an antiviral administration, if required) could have been established earlier potentially limiting the additional spread of infection and enabling the outbreak to be under control sooner. Further review of the TPH letter indicated there was one resident death related to the outbreak.

During an interview, ADOC #134 verified the information documented in the letter. Therefore, the home failed to ensure staff participated in the implementation of

the infection prevention and control program.

2. The inspector reviewed the next respiratory outbreak that was reported by the home.

Record review of the home's infection control and outbreaks documentation indicated that during a specific period, the home reported respiratory outbreak to the Ministry of Long-Term Care and Public Health agency. A review of the home's outbreak records, including residents and staff line listing, indicated that a specific number of residents and one staff member were experiencing respiratory symptoms which included several symptoms, since a specific date, prior to the report of an outbreak.

Record review the TPH summary letter addressed to the home confirmed the following:
The home experienced a respiratory outbreak during a specific period of time. Outbreak control measures were established by the Outbreak Management Team in consultation with Toronto Public Health and were maintained for the period. During this period, restrictions were placed on admission and re-admission to the affected units. Two identified strains were the causative agent identified for this outbreak.

During an interview, ADOC #134 verified the information documented in the letter and also verified that the staff should have called Public Health and reported the outbreak earlier. Therefore, the home failed to ensure staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

3. The Director received a complaint related to resident #003's altered skin integrity.

Record review of the progress notes indicated that resident #003 was observed to have altered skin integrity on a specific month. This information was verified during separate interviews with the resident's substitute decision-maker (SDM) #169 who attended the home, and registered staff RPN #108.

Further record review of primary physician #167's progress notes indicated that the physician suspected the altered integrity might be an identified condition since the resident was successfully treated with specific medication. However, the progress notes also revealed that the resident was re-infected because strict

contact precautions were not implemented, along with coordinated efforts between departments to ensure deep cleaning and laundering of affected residents personal effects, such as clothing, rooms, linen, curtains and furniture, thorough the housekeeping and the laundry departments.

During an interview, ADOC #134 stated, ‘if you remotely suspect the resident has an identified condition, you want to look at the room the resident is in and make sure that everything in the room was treated including other residents. If possible, the resident should be relocated to a private room or cohorted with other affected residents; and open communication to all staff so that they are aware to use applicable personal protective equipment when interacting with that/those resident (s)’. As noted, the implementation of isolation related to contact precautions and the use of personal protection equipment (PPE) were not implemented at the time resident #003 was treated. Therefore, the home failed to ensure staff participated in the implementation of the infection prevention and control program.

The inspector was not able to interview the management team who were directly involved with prior outbreaks since the ED, both DOCs, the ADOC and the Director of Environmental Services were no longer working in the home.

Record review of the previous NM #178’s email on a specific date indicated that a resident on the third floor may have the identified condition and treatment was initiated. The email further indicated to have housekeeping clean and vacuum the room. The email does not indicate that the resident was placed on isolation precautions. Review of the home’s line listing for the condition monitoring did not include any residents on the third floor.

In an interview with RPN #108, they stated that a resident on a specific floor was identified with the identified condition and was provided treatment. Review of the home’s line listing for the identified monitoring did not include any residents on the identified floor. They also indicated that there was one staff that was identified with a confirmed case.

In an interview with resident #003’s SDM #169, they indicated that they had a confirmed case requiring treatment and that they contracted this at the home as they were visiting the resident daily. Record review of the home’s policy titled “ Identification & Management”, revised April 2019, indicated the following:

-Control measures for single or multiple cases should consist of heightened

surveillance for early detection of new cases, proper use of infection control measures when residents, confirmation of the diagnosis, early and complete treatment and follow-up cases, and prophylactic treatment of team members and other residents who had prolonged skin-to-skin contact with suspected and confirmed cases. In addition, a care community wide information program should be implemented to instruct all management, medical, nursing, and support team members about the condition and how it is and is not spread. Epidemiological and clinical data should be reviewed to determine the extent of the outbreak and risk factors for spread';
-until successfully treated, residents with the condition should be isolated from other resident who do not have it;
-long term surveillance for the condition is imperative to eradicate it from a care community. All new residents should be screened and treated for skin conditions suggestive of the condition.

A review of the outbreak documents, progress notes, pharmacy provided medication administration records, housekeeping and laundry documentation records indicated that residents with suspected cases were often treated medically, but without the coordinated efforts and involvement of the housekeeping, maintenance, laundry and infection prevention and control programs. Although residents residing on other floors in the home were identified as suspected cases, fulsome treatment and other measures to control and eradicate the condition were implemented only on a specific floor in 2017 and in 2019. Therefore, newly admitted residents remain vulnerable to being infected. [s. 229. (4)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license has failed to ensure that resident #023 had the right to participate fully in making any decision concerning any aspect of their care.

The Director received a complaint related to resident #023 not consenting to having one to one monitoring.

Record review of resident #023's clinical health record showed that they had no cognitive impairment.

In an interview with resident #023, they indicated that they were not provided a consistent reason as to why they were placed with one to one monitoring. They indicated that they were informed that they would be moving from their private room to basic accommodation and a one to one would be assigned to facilitate the transfer. The move never occurred and the reason for the one to one monitoring changed to concerns regarding safety from other residents, and then due to their responsive behaviours. Resident #023 indicated that they repeatedly asked not to have one to one monitoring. The one to one monitoring was discontinued three weeks later as per the resident.

Record review of resident #023's progress notes by ADOC #134, showed that on a specific date, resident was placed on one to one for support to facilitate the transfer of rooms. Another progress note by the behavioural support outreach

(BSO) #115, on the same date, indicated that one to one support was initiated for resident #023 for safety.

Further review of the progress notes indicated that resident #023 was refusing one to one monitoring on the day it was implemented. Two days later, the resident was questioning why they were on one to one and did not feel as though they required it.

In an interview with BSO #115, they indicated that one to one monitoring was initiated initially as resident exhibited responsive behaviour about the room change and also due to the resident's previous history of behaviours. They further indicated that the resident did not vocalize any potential harm at the time the one to one was placed. They further indicated that they were unsure why the resident was not moved from their private room and did not know who informed the resident why the move would not occur. BSO #115 stated that they knew that resident #023 did not want the one to one monitoring in place.

Record review of resident #023's progress notes written by BSO #115 showed that resident #023 inquired about their private room and BSO #115 stated that they did not hear anything about moving the resident from their private room. Further review of the progress notes did not show that resident was informed that the room change was stopped.

A review of the progress notes showed that a specific risk assessment was completed, which indicated that resident had verbally stated that they had no risk for harm. The one to one monitoring continued after this assessment. Further review of the progress notes did not indicate any further assessments were completed at the time of the one to one monitoring being initiated. The one to one monitoring was discontinued on a specific date as resident did not pose a risk to themselves and at the recommendation of the resident's external consultant.

Record review of resident's care plan with full revision history did not indicate any reason why resident was placed on one to one monitoring, or what staff should be monitoring for. Further review of the resident's care plan showed that a month after, the care plan was updated to indicate the following: "I do not like to be placed on 1:1 staff monitoring".

In an interview with DOC #101 indicated that the resident was informed of the decisions regarding one to one monitoring and that the BSO nurse would have

informed the resident that the room change would not be occurring.

The licensee has failed to ensure that resident #023's right to have their participation in decision-making respected. The resident was placed on one to one monitoring to support the resident change from a private to basic room. The room change never occurred, the resident was not informed and continued to be placed on one to one monitoring despite vocalizing that they did not want it. No behaviour assessments were completed to assess resident #023's need for one to one monitoring. Therefore, the home has failed to ensure that resident #023's rights to participate in decision-making was respected. [s. 3. (1) 9.]

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 every resident has the right to have his or her participation in decision-making respected, to be implemented voluntarily.

WN #4: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #002 and #003.

The Director received a complaint related to personal care concerns.

A review of the resident's activities of daily living – Support Action document from Point of Care (POC) documentation system indicated that on thirty two dates, the resident's evening care (2130 hours) provided by PSWs were not documented.

During an interview, PSW #163 reviewed the Support Actions documentation and acknowledged that the documentation was missing on those specified dates. The PSW also verified that if care was provided there should have been a time and initials in the empty slots.

During an interview, ADOC #134 acknowledged that direct care staff should have documented in POC when personal care was provided to the resident.

b. The Director received a complaint related to personal care concern.

A review of the resident's activities of daily living (ADL) – Support Action document from the Point of Care (POC) documentation system indicated that on thirteen dates the resident's day, evening and night care needs provided by PSWs, were not documented.

During an interview, PSW #163 reviewed the Support Actions documentation and acknowledged that the documentation was missing on those specified dates. The PSW also verified that if care was provided there should have been a time and initials in the space provided.

During an interview, ADOC #134 acknowledged that direct care staff should have documented in POC when personal care was provided to the resident. [s. 6. (9) 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 that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #003 was bathed, at a minimum, twice a week by a method of his or her choice, including tub bath, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Director received a complaint related to personal care concern.

Record review of resident #003's activities of daily living (ADL) – Bathing records indicated that the resident was to be showered twice each week on specific days. However, the resident's Point of Care electronic documentation bath records indicated that the resident missed their shower on three separate dates.

During the inspection, the primary PSW was not available to be interviewed, however, RPN #172 verified that the showers were likely missed as a result of the resident's refusal to be showered. RPN #172 stated that sometimes the resident refused to be showered, however personal care should be provided by the PSW in the form of a sponge bath. The RPN also stated that in the past, because of the resident's responsive behaviors, the resident's substitute decision-maker would attend the home to help staff provide the resident's showers. Therefore, the home failed to ensure resident #003 was bathed, at a minimum, twice a week. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's pain management program to identify and manage pain in residents was implemented in the home.

Review of the home's policy titled "Pain symptom and Management Program, #VII-G-30.30" last reviewed on April 2019, directed staff members to provide ongoing pain assessments to optimally control and manage pain and document effectiveness of pain medications using pain scale. The policy directed staff members to complete pain assessment when a resident is a new admission, when there is a significant change with the resident condition, when resident exhibits sign and symptom of pain and when pain is not relieved following the initial pain treatment. The home's pain management policy under fall-prevention and management program, also states that when a resident has fallen, registered staff should complete pain assessment using the Initial Post-Fall assessment tool; complete a thorough assessment to identify gross injuries and extreme pain, and to observe non verbal pain markers such as guarding, facial expressions and tensions.

Record review of the progress notes indicated that on five separate dates, the resident experience pain post fall with altered skin integrity.

Further review of the records did not indicate a pain assessment was completed after the resident sustained multiple altered skin integrity, when they verbalized pain and after they exhibited non verbal markers of pain. There was no pain assessment completed between a specific period of time. There was no documentation available describing the type, severity, quality, onset, duration, and precipitating factors of the pain. Review of the medication administration records indicated that treatments for pain was provided only on one specific date.

Interviews with DOC confirmed that the registered staff did not complete pain assessments and provide treatments when resident #012 exhibited pain. The DOC indicated that under the home's pain management program, registered staff are expected to complete pain assessments using the home's specified pain assessment tools when a resident exhibits pain and provide treatments and confirmed that the registered staff did not implement the home's pain management program for resident. [s. 48. (1) 4.]

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 pain management program to identify pain in residents and manage pain is implemented in the home, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The license has failed to ensure that the actions taken to meet the needs of resident #023 included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

The Director received a complaint related to resident #023 not consenting to having one to one monitoring.

Record review of resident #023's progress notes by ADOC #134, showed that on a specific date, resident was placed on one to one for support to facilitate change from private room to shared room on a different floor. Another progress note by the BSO #115, on the same date indicated that one to one support was initiated for resident #023 for safety. Further review of the progress notes indicated that resident #023 was refusing one to one monitoring on two separate dates.

In an interview with BSO #115, they indicated a resident would require one to one support for various reasons. BSO #115, they indicated that one to one monitoring was initiated initially for resident #023 because they were they exhibited specific responsive behaviours.

Review of the progress notes did not indicate resident was assessed. A risk assessment was completed nine days after the resident was placed on one to one monitoring which indicated that the resident had verbally indicated that they were not at risk for harm. Review of the resident's dementia observational system (DOS) tool showed incomplete documentation and no analysis into the resident's behaviour. Further review of the resident's plan of care did not indicate any other assessment or reassessment related to the one to one monitoring for resident #023.

In an interview with the DOC, they indicated that prior to placing one to one monitoring, assessments and all other interventions would be exhausted. DOC #101, stated resident #023 was placed on one to one monitoring as resident was displaying behaviours because of being moved from their private room to a shared basic room. DOC stated they would have expected a risk assessment to be completed at the time of placing the one to one monitoring, and an ongoing assessment of the resident's behaviour. They acknowledged that for resident #023, assessments and documentation was not completed appropriately. [s. 53. (4) (c)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions developed were implemented to assist residents and staff who are at risk of harm or who were harmed as a result of resident #002's behaviors including responsive behaviors, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

The Director received a complaint related to responsive behaviors.

Record review of the progress notes indicated resident #002 had engaged in multiple altercations with other residents on the unit and with staff members. On two identified dates, progress notes indicated that the resident attempted to physically hit two separate staff members with their mobility device during both altercations. During another incident the resident attempted to enter another resident's room when the staff members entered for their own protection and safety.

Record review also indicated that on multiple occasions, the resident angrily stated specific phrases to staff or other residents when they were angry and upset about an incident which occurred.

Record review of the resident's plan of care indicated to keep resident #002 a safe distance away from specific residents who reside on the same unit, since the resident does not get along with them, and had engaged in altercations with those residents. However, all residents were currently residing on the same unit. Further review of the plan of care did not indicate any additional behavioural interventions.

During an interview, registered staff RPN #172, RN #164 and BSO Nurse #115 verified the above altercations had occurred. The BSO Nurse indicated that the resident was being followed by external resources following one of the incidents.

Record review indicated that the home has a Code White process/procedure/policy which was not activated or implemented during these incidents of aggression displayed by resident #002. This information was verified during an interview with the BSO Nurse. The resident's written plan of care included a statement indicating when to call a code white. Therefore, the home failed to ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of resident #002's behaviors. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was developed for resident #021 related to their specific condition.

The Director received a complaint regarding the monitoring and assessment of resident #021, which resulted in the resident being transferred to hospital and subsequently passed away from two specific conditions.

Record review of resident #021's clinical health record showed the resident had an identified chronic condition.

Review of resident #021's care plan with full revision did not indicate a focus related to their identified chronic condition. Record review of resident #021's progress notes indicated that the family told staff that the resident had this chronic condition. Further review of progress notes did not indicate an interdisciplinary discussion was conducted regarding the management of resident #021's identified chronic condition.

In an interview with RPN #113, they indicated that for residents with the identified chronic condition, they would monitor specific vital signs and physical changes. They further indicated that this would be integrated into the plan of care.

In an interview with DOC, they indicated that for residents who have this chronic disease, they would expect staff to closely monitor residents including their vital signs, physical changes, and inform the physician of any changes. They further indicated that they would have expected staff to have a plan of care in place for the resident. DOC #101 indicated that a care conference would occur at admission and anything the family points out, it would be discussed. [s. 26. (3) 9.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food was served at a temperature that was palatable to resident #001.

The Director received a complaint related to dining services.

On November 21, 2019, the inspector observed the process of delivering food items from the kitchen, setting up the steam table and serving of the lunch meal on the second floor. The full meal service was observed for both the first and second seating. After checking and recording meal items temperature, dietary aide #109 poured approximately six to eight bowls of soups, regular and pureed texture, which sat on a tray ready to be served by assigned PSWs for approximately 15 to 20 minutes uncovered. Inspector also observed that while plating residents' meals, dietary aide #109 kept the lids open on the hot food items at the steam table. Lids were replaced prior to retrieving desserts from the fridge to serve residents.

Record review of the November 21, 2019, menu temperature log at lunch indicated a drop-in temperature of approximately three to eight degrees Celsius between the first and second seating of meal service.

On November 28, 2019, at approximately 1310 hours, the inspector observed resident #001 having their lunch meal on second seating in the second-floor dining room. During an interview, resident #001 stated that their meals were barely warm compared to the way they would like for it to be served. Inspector spoke with two other residents in the dining room during that same meal service, and both responded that the temperature of their meals was adequate for them to enjoy.

During separate interviews, dietary aide #109 and Director of Food Services #107 verified that soups should have been poured immediately before serving to each resident and, hot food items should remain covered when not in use to keep food items as hot as possible prior to serving each portion. Therefore, the home failed to ensure that hot food items were maintained at a temperature that was palatable to resident #001. [s. 73. (1) 6.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odors.

The Director received a complaint related to housekeeping concerns.

On November 20, 21, 2019, the inspector noted that there was a lingering offensive odor of urine in the hallway outside specific rooms. During an interview with Housekeeping aide #111 who acknowledged the presence of an odor and was assigned to clean the unit, stated that they were required to use disinfectant to clean the floors; however, they did not have any specific solution available to address lingering odors. The inspector suggested that the housekeeping staff discuss the concern with their supervisor to address the issue.

On November 28, 2019, the inspector noted the lingering odor in the same area of the unit was unchanged from the previous visit.

During interviews with Director of Environmental Services (DES) #171 and Housekeeping Supervisor #106, both acknowledged that there was still a lingering odor coming from inside a specific room despite additional cleaning in the room and washroom with odor eliminating chemicals. DES #166 confirmed an action plan was set in place to implement the following strategies to eliminate the odor in the room: the washroom would be painted; housekeeping aide would wipe and clean the resident's bedside rails daily, where the resident's medical device hung, and which was a source of potential leakage of bodily fluids onto the floor during the night shift.

During an interview, registered staff RPN #110 acknowledged the presence of a lingering odor in the area and informed the inspector that resident #004 had a medical device. The RPN stated that components of the medical device were being rinsed and reused, and that the practice was immediately changed so disposables were used daily, as suggested in the instruction package.

Therefore, the licensee failed to ensure that procedures were developed and implemented to address incidents of lingering offensive odors in the home. [s. 87. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #021, the correct SDM was contacted when the resident was transferred to the hospital.

The Director received a complaint regarding the assessment of resident #021 and the home calling the incorrect contact when resident was sent to the hospital.

Record review of resident #021 clinical health record on pointclickcare (PCC) indicated family member (FM) #200 was the primary contact and FM #201 was the secondary contact.

In an interview with FM #201, they indicated that they told the staff at the home they would be away and should there be any concerns, FM #200 should be contacted.

Record review of resident #021 progress notes indicated the resident was found with acute change to their health status and was subsequently sent to the hospital. Further review of the progress notes indicated that the nursing staff left a message for FM #201 regarding the transfer of the resident to the hospital.

In an interview with DOC #101, they indicated that staff should be contacting the appropriate individual that is outlined by the power of attorney (POA) or resident. [s. 107. (5)]

WN #13: 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 resident #021's written records were retained by the licensee for at least 10 years after the resident is discharged from the home.

Inspector requested resident #021's chart from the ED #100 on November 19, 20, and 21, 2019, for review. The resident was admitted to the home in April 2019, and was subsequently transferred to hospital on four days later. Resident #021 did not return back to home after they were hospitalized.

ED #100 stated that they could not locate resident #021's chart in their archives and was unable to provide the inspector with the resident's chart. [s. 233. (1)]

Issued on this 22nd day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by PRAVEENA SITTAMPALAM (699) - (A1)
Inspection No. / No de l'inspection :	2019_780699_0024 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019835-18, 026393-18, 008815-19, 012751-19, 014326-19, 014792-19, 015239-19, 016725-19, 019507-19, 020170-19, 021496-19, 022259-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 22, 2020(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 :	Lora Monaco

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

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

The licensee must be compliant with r. 50. (2).

Specifically, the licensee must ensure:

1. Resident #003, #025 and any other resident exhibiting altered skin integrity, receives a skin assessment by a registered staff member, using the appropriate assessment instrument that is specifically designed for skin and wound assessment.
2. Any resident exhibiting altered skin integrity, receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevention.
3. Any resident exhibiting altered skin integrity, is reassessed at least weekly by a member of the registered staff, if clinically indicated.
4. Develop and implement a monthly audit to monitor the completion of skin assessments for all resident's who exhibit altered skin integrity. The audit is to include but not limited to the following information: unit name, date of audit, person completing the audit, resident assessment audited, outcome of audit, follow up actions; and other relevant information included.

Grounds / Motifs :

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

1. The licensee has failed to ensure that residents exhibiting altered skin integrity including skin breakdown: (i) received 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 and (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A complaint was received by the Director regarding the alleged incident of abuse and neglect of resident #012. The complaint stated that the resident had altered skin integrity on a specific area of their body.

The home's policy titled, "Skin and Wound Care Program Management, #VII-G-10.80", revised on April 2019, directed registered staff members to conduct a head to toe and skin assessments, when a resident has altered skin conditions such as skin tear and bruises. The policy also directed staff members to initiate treatments immediately, to promote healing and prevent infection.

Record review of the progress notes indicated that resident #012 had a fall on a specific date and sustained an altered skin integrity on an identified part of their body. The notes indicated that the initial skin and head to toe assessments were not completed following the fall. There was no treatment initiated. The records indicated that RN #114 completed the initial skin and head to toe assessment five days after the incident.

Interview with RN #114 confirmed that there was no initial skin and head to toe assessments completed following the fall incident. They indicated that they completed the required assessment and initiated treatments, five days after the fall. RN #114 reiterated that it was the expectation of the home to complete a head to toe and skin assessments immediately after a resident has altered skin conditions, initiate treatments and document the findings.

Interview with the DOC indicated that it was the home's expectation that registered staff complete skin assessments using the home's skin assessment tool when a resident has altered skin conditions and initiate treatments. They confirmed that the registered staff did not use the assessment tool, initiate treatments and document findings as expected. (645)

2. The licensee has failed to ensure that resident #034's altered skin integrity received 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.

The Director received a complaint from resident #034's SDM in regards to an abuse investigation conducted by the home.

During a conversation, resident #034's SDM expressed their concerns related to the resident's altered skin integrity of unknown cause to the inspector. On November 28, 2019, the inspector received an email from resident #034's SDM. The email contained 20 images of altered skin integrity on different locations of the body between a specific time period.

Review of the home's "Skin & Wound Care Management Protocol" policy #:VII-G-10.90 (page 3), indicated when a resident is experiencing intact skin alterations, i.e. excoriation, rashes, bruises, staff are to complete an electronic head to toe Assessment weekly until healed.

Review of resident #034's progress notes, assessments and the images provided by resident #034's SDM, indicated a skin assessment had not been completed by a registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for two identified altered skin integrity on two separate dates.

In an interview, ADOC #134 stated a head to toe assessment should be completed by registered staff for any altered skin integrity. ADOC #134 acknowledged there was no documentation in the progress notes regarding the above mentioned altered skin integrity, and there was no skin assessment completed for the altered skin integrity as required. (507)

3. The licensee has failed to ensure that resident #034, #003 and #025's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a. Review of resident #034's progress notes indicated an altered skin integrity was observed on a specific date. Review of the skin and wound care assessments indicated the skin and wound assessment had not been completed on two separate

dates.

Review of resident #034's progress notes indicated an altered skin integrity on a different identified area was observed on a specific date. Review of the treatment administration record (TAR) for an identified month indicated an order for an identified altered skin integrity. Review of the weekly skin and wound care assessments indicated the skin and wound care assessments had not been completed for the identified altered skin integrity on six separate dates.

In an interview, ADOC #134 stated a head to toe assessment should be completed by registered staff for any altered skin integrity. A skin and wound care assessment should be completed for any open altered skin integrity, such as skin tear, pressure ulcer or wound. The skin and wound care assessment should be completed weekly until healed. ADOC, #134 acknowledged the above mentioned skin and wound assessments were not completed as required.

b. The Director received a complaint related to resident #003's altered skin integrity.

Record review indicated that resident #003 was admitted to the home and was assessed using the home care assessment tool prior to their admission which indicated no skin condition. The home's quarterly RAI-MDS assessment on a later date, indicated different altered skin integrity with skin treatment.

Record review of the progress notes indicated the resident started getting altered skin integrity on a specific area of their body in a specific month. This information was verified during separate interviews by the resident's substitute decision-maker (SDM) #169 who attended the home daily, and registered staff RPN #108. Further review of the progress notes indicated that resident #003 continued to be seen by the physician a month later for their altered skin integrity.

Record review of the resident's skin assessment records indicated there were few documented skin assessments to be located. The inspector requested the home's Skin and Wound Care Lead #174 to locate the resident's weekly skin assessments documentation for the period of when the altered skin integrity began until it resolved.

On December 10, 2019, weekly head to toe assessments related to the above

mentioned altered skin integrity were presented to the inspector by the Skin and Wound Care lead #174. However, there were no weekly completed head to toe assessments for the identified altered skin integrity for two specific months.

During an interview, the Skin and Wound Care Lead verified that residents with altered skin integrity should receive a documented weekly skin assessment to assess the status of the skin and ensure current treatment is successful or whether a reassessment is required. Therefore, the home failed to ensure resident #003's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

c. The Director received a critical incident system (CIS) report related to resident to resident abuse. Review of the CIS showed that an altercation between resident #026 and resident #025 occurred.

Record review of resident #025's progress notes indicated that the resident sustained specific altered skin integrity to a specific area of their body as result of a resident to resident altercation. Further review of the progress notes indicated that on a specific date, the altered skin integrities were still visible. The progress notes did not indicate when they healed.

Review of resident #025's initial skin assessment on the day of the altercation showed several areas of altered skin integrity to specific areas of their body.

Record review of the assessments in pointclickcare (PCC) did not reveal any weekly skin assessments completed for the resident's altered skin integrity.

Review of the home's "Skin & Wound Care Management Protocol" policy #:VII-G-10.90 (page 2), indicated when a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, staff to:
- Initiate and complete electronic weekly skin and wound assessment.

In an interview with RPN#116, they indicated that weekly skin assessments should be completed utilizing the skin assessment form. They further stated that a weekly skin assessment should have been completed for resident #025.

The severity of this issue was determined to be a level 2 as there was minimal risk to

the residents. The scope of the issue was a level 2 as it related to two out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Voluntary Plan of Correction (VPC) issued May 24, 2017 2017_430644_0004;
-VPC issued December 21, 2018 , 2018_630589_0011;
-Compliance Order (CO) issued March 14, 2019 2019_324535_0003;
-VPC issued June 6, 2019, 2019_650565_0011; and
-Written notification (WN) issued August 6, 2019, 2019_808535_0010. (507)

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee will be compliant with s. 229 (4) of the O. Regulations.

Specifically, the licensee must:

1.Educate all staff, including the management team, about outbreak detection/surveillance and outbreak reporting requirements, specifically related to respiratory infections. A written record must be kept regarding the training content, who will be responsible for providing the education, and the dates the training will occur.

2.Demonstrate that staff have understood the education and their ability to implement outbreak detection/surveillance and outbreak reporting requirements.

3.Ensure resident #003 and all other residents in the home are assessed by a registered staff and/or physician for the presence of the identified condition. If the registered staff and/or physician has assessed a resident to potentially have this condition, the home's policy must be initiated.

4.Maintain written documentation of the assessments conducted and any treatments initiated for each resident.

5.Train all staff, including management, on the home's policy related to the identified condition. A written record must be kept regarding the training content, who will be responsible for providing the education, and the dates the training will occur. A written record of attendance must be kept.

6.Demonstrate that staff have understood the education and their ability to implement the policy.

Grounds / Motifs :

1. The licensee has failed to ensure staff participated in the implementation of the infection prevention and control program.

The MLTC received a complaint related to the home's infection control practice.

Record review of the home's infection control and outbreaks documentation indicated

that on a specific date, the home reported respiratory outbreak to the Ministry of Long-Term Care and Public Health agency. A review of the homes outbreak records, including residents and staff line listing, indicated that a specific number of residents and staff member were experiencing respiratory symptoms prior to the report of an outbreak to the above mentioned authorities.

Record review of the Toronto Public Health (TPH) summary letter addressed to the home confirmed the following:
"The home experienced a respiratory outbreak during an identified period. During this period, restrictions were placed on admission and re-admission to the affected units – the outbreak was for the 'entire facility'. Two identified strains were indicated as the causative agents for this outbreak. Toronto Public Health recommends the following in order to improve outbreak management in the home: Educate staff about Outbreak Detection (Surveillance) and Outbreak Reporting Requirements".

The letter continued to say: "Timely reporting of outbreaks (including week nights and week-ends) is also an essential component of outbreak (OB) management as per the Health Protection and Promotion Act, R.S.O. 1990 c. H. 7, O. Reg. 135/18".

TPH was notified about this outbreak on a specific date at which an identified number of residents from an identified floor were experiencing acute respiratory symptoms. As indicated on the line list, the earliest onset dates were on several days prior to when TPH was notified. As per the TPH letter, had TPH been notified on that date a respiratory outbreak would have been declared and infection prevention and control measures, specimen collection and testing could have been implemented in a timely manner. Specimen results and addition preventative interventions (such as an antiviral administration, if required) could have been established earlier potentially limiting the additional spread of infection and enabling the outbreak to be under control sooner. Further review of the TPH letter indicated there was one resident death related to the outbreak.

During an interview, ADOC #134 verified the information documented in the letter. Therefore, the home failed to ensure staff participated in the implementation of the infection prevention and control program.

(535)

2. The inspector reviewed the next respiratory outbreak that was reported by the home.

Record review of the home's infection control and outbreaks documentation indicated that during a specific period, the home reported respiratory outbreak to the Ministry of Long-Term Care and Public Health agency. A review of the homes outbreak records, including residents and staff line listing, indicated that a specific number of residents and one staff member were experiencing respiratory symptoms which included several symptoms, since a specific date, prior to the report of an outbreak.

Record review the TPH summary letter addressed to the home confirmed the following:
The home experienced a respiratory outbreak during a specific period of time. Outbreak control measures were established by the Outbreak Management Team in consultation with Toronto Public Health and were maintained for the period. During this period, restrictions were placed on admission and re-admission to the affected units. Two identified strains were the causative agent identified for this outbreak.

During an interview, ADOC #134 verified the information documented in the letter and also verified that the staff should have called Public Health and reported the outbreak earlier. Therefore, the home failed to ensure staff participated in the implementation of the infection prevention and control program. [s. 229. (4)] (535)

3. The Director received a complaint related to resident #003's altered skin integrity.

Record review of the progress notes indicated that resident #003 was observed to have altered skin integrity on a specific month. This information was verified during separate interviews with the resident's substitute decision-maker (SDM) #169 who attended the home, and registered staff RPN #108.

Further record review of primary physician #167's progress notes indicated that the physician suspected the altered integrity might be an identified condition since the resident was successfully treated with specific medication. However, the progress notes also revealed that the resident was re-infected because strict contact precautions were not implemented, along with coordinated efforts between departments to ensure deep cleaning and laundering of affected residents personal effects, such as clothing, rooms, linen, curtains and furniture, thorough the housekeeping and the laundry departments.

During an interview, ADOC #134 stated, 'if you remotely suspect the resident has an identified condition, you want to look at the room the resident is in and make sure that everything in the room was treated including other residents. If possible, the resident should be relocated to a private room or cohorted with other affected residents; and open communication to all staff so that they are aware to use applicable personal protective equipment when interacting with that/those resident (s)'. As noted, the implementation of isolation related to contact precautions and the use of personal protection equipment (PPE) were not implemented at the time resident #003 was treated. Therefore, the home failed to ensure staff participated in the implementation of the infection prevention and control program.

The inspector was not able to interview the management team who were directly involved with prior outbreaks since the ED, both DOCs, the ADOC and the Director of Environmental Services were no longer working in the home.

Record review of the previous NM #178's email on a specific date indicated that a resident on the third floor may have the identified condition and treatment was initiated. The email further indicated to have housekeeping clean and vacuum the room. The email does not indicate that the resident was placed on isolation precautions. Review of the home's line listing for the condition monitoring did not include any residents on the third floor.

In an interview with RPN #108, they stated that a resident on a specific floor was identified with the identified condition and was provided treatment. Review of the home's line listing for the identified monitoring did not include any residents on the identified floor. They also indicated that there was one staff that was identified with a confirmed case.

In an interview with resident #003's SDM #169, they indicated that they had a confirmed case requiring treatment and that they contracted this at the home as they were visiting the resident daily. Record review of the home's policy titled " Identification & Management", revised April 2019, indicated the following:

-Control measures for single or multiple cases should consist of heightened surveillance for early detection of new cases, proper use of infection control measures when residents, confirmation of the diagnosis, early and complete

treatment and follow-up cases, and prophylactic treatment of team members and other residents who had prolonged skin-to-skin contact with suspected and confirmed cases. In addition, a care community wide information program should be implemented to instruct all management, medical, nursing, and support team members about the condition and how it is and is not spread. Epidemiological and clinical data should be reviewed to determine the extent of the outbreak and risk factors for spread';
-until successfully treated, residents with the condition should be isolated from other resident who do not have it;
-long term surveillance for the condition is imperative to eradicate it from a care community. All new residents should be screened and treated for skin conditions suggestive of the condition.

A review of the outbreak documents, progress notes, pharmacy provided medication administration records, housekeeping and laundry documentation records indicated that residents with suspected cases were often treated medically, but without the coordinated efforts and involvement of the housekeeping, maintenance, laundry and infection prevention and control programs. Although residents residing on other floors in the home were identified as suspected cases, fulsome treatment and other measures to control and eradicate the condition were implemented only on a specific floor in 2017 and in 2019. Therefore, newly admitted residents remain vulnerable to being infected.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to three out of three residents reviewed. The home had a level 3 history as there were 1 or more related non-compliances issued to the same subsection that included:

-Voluntary Plan of Correction (VPC) issued October 17, 2017, 2017_324535_0014. (535)

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Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2020(A1)

Order(s) of the Inspector

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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

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 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

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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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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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 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 22nd day of April, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by PRAVEENA SITTAMPALAM (699) - (A1)

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