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 sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_268604_0013	012651-16	Resident Quality Inspection

Licensee/Titulaire de permis

PORANGANEL HOLDINGS LIMITED
2231 MEDHAT DRIVE MISSISSAUGA ON L5B 2E3

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

KING CITY LODGE NURSING HOME
146 Fog Road King City ON L7B 1A3

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

SHIHANA RUMZI (604), JENNIFER BROWN (647), MATTHEW CHIU (565), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 2, 3, 4, 5, 6, 7, 9, 10, 11, and 12, 2016.

The following intakes were inspected concurrently with the Resident Quality Inspection: Critical Incident Report intakes related to misappropriation of funding Log #006267-14. The following intakes where related to alleged neglect in the home: Log #009966-14, Log #006622-15, 013463-15, Log #006622-15, Log #003631-16, Log #007337-16, and Log # 012670-16. The following intakes where related to alleged abuse in the home: Log #028840-15, Log #009107-15, and Log #001178-16 was related to entrapment.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Associate Nurse Manager(s) (ANM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Manager (MM), RAI-Coordinator (RC), Cook, Life Enrichment Coordinator (LEC), Housekeeping Aide (HA), Nursing Administrative Assistant (NAA), Registered Dietitian (RD), Dietary Manager (DM), Physiotherapy Assistant (PTA), Residents, Substitute Decision Makers (SDMs), Presidents of Residents' and Family Councils.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service, medication administration, staff and resident interactions, provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Residents and Family Council meetings, relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health & Long-Term Care (MOHLTC). The CIS report indicated resident #042 was found on last rounds, by Registered Nurse (RN) and Personal Support Worker (PSW) to be trapped in an identified residents personal equipment. The resident was transferred to hospital for further assessment for his/her injuries.

An interview with RN #118 indicated he/she worked on an identified day and shift, with a part-time PSW. The RN stated he/she carried out second rounds at an identified time, with the PSW, and resident #042 was positioned on his/her right side. The RN stated when he/she went back with the PSW for third rounds and resident #042 had rolled on his/her back and observed the resident was trapped in the identified residents personal equipment. The RN further indicated the resident could move himself/herself in the past but was not able to move himself/herself recently due to deterioration and was not sure how he/she got himself/herself trapped in the resident personal equipment. The RN went on to state resident was in pain as the resident was being released from the identified resident personal equipment and observed cyanosas on an identified area of the resident's body and the resident had sustained injuries which needed further assessment

and was transferred to hospital.

An identified home’s policy with a revised date of May 25, 2015, indicates under standards #2: The need for resident personal equipment to be reassessed with any changes in the resident’s status or at least quarterly to reduce the risk of harm to residents.

Minimal Data Systems (MDS) assessment for a specified date, indicated the resident utilized identified resident personal equipment for daily care.

The written plan of care for a specified dated indicated resident #045 utilized the identified resident personal equipment for positioning.

A review of the home's January 2015, bed assessment an identified assessment indicated the identified personal equipment was assessed and not for the use of resident #042's needs. This was contrary to what RN #118 indicated, which was that resident #042 did utilize identified resident personal equipment all of the time. When interviewed the Maintenance Manager (MM) indicated he/she is unaware if an identified assessment being conducted specifically to assess resident #042 and possible areas of risk and further indicated only the equipment was assessed.

Interviews conducted with the DON and Administrator confirmed that resident #042 was trapped in an identified resident personal equipment and sustained injuries which needed further assessment and had to be transferred to hospital. The DON and Administrator confirmed resident #042 had not been assessed for the use of the resident personal equipment and resident personal equipment had not been evaluated in accordance with evidence-based practices to minimize risk for resident #042.

The inspector found the home had failed to ensure that resident #042’s individual resident personal equipment was assessed and the residents personal equipment system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident whereby steps were taken to prevent resident risk, taking into consideration all potential areas of risk and other safety issues related to the use of the identified resident personal equipment where addressed. As a result, resident #042 sustained actual harm when the resident got trapped in the identified resident personal equipment.

The severity of the non-compliance and the severity of harm and risk is actual harm as

resident #042 sustained injuries which needed further medical assessment and was transferred to hospital.

The scope of the non-compliance is isolated.

A review of the home's past compliance history revealed non-compliance related to the Long-Term Care Homes Act, O.Reg 79/10, s. 15. (1). A voluntary plan of correction (VPC) was previously issued under O.Reg 79/10, s. 15. (1) (c) during a Resident Quality Inspection (RQI) issued to the home on January 29, 2015, under Inspection # 2015_340566_0002.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

The home submitted a CIS report on an identified date, to the Ministry of Health and Long-term Care (MOHLTC). The CIS report indicated a staff member posted personal health information of two residents residing in the home on a social media site on an identified date.

An interview with Housekeeping Aide (HA) #124 revealed that on an identified date, he/she had engaged in a conversation with resident #007. HA #124 indicated that resident #007 vocalized how upset he/she had been with his/her new roommate and stated that resident #011 "is an animal".

The HA further indicated that as a result of resident #007's statement regarding his/her new roommate and the resident's attitude, the HA had become upset and felt frustrated. The HA stated that because he/she was so upset, decided to post his/her feelings on an identified social media site. HA #124 confirmed that on an identified date and time, he/she posted his/her negative feelings toward resident #007 and had included one of resident #011's medical diagnoses, without mentioning resident names. On the same evening of the identified date and time, the HA indicated that he/she decided to remove the post and had replaced it with positive comments and status.

Interviews conducted with HA #115, Physiotherapy Assistant (PTA) #125 and Nursing Administrative Assistant (NAA) #117 revealed that they had communicated with HA #124 on a internet public media site. The staff indicated that they had seen HA #124's post on the identified date and public media site and all staff were able to identify who the two residents were based on the information posted. The staff indicated that although resident names had not been posted on the social media site, the social media site post had stated resident #011's medical diagnosis and living arrangements of resident #007 and #011, which permitted the identification of the two residents.

An interview with the Administrator confirmed that on an identified date and identified time frame HA #124 had posted identifying information of two residents in the home on

his/her identified social media site. HA #124 received a seven day suspension and completed applicable education. The Administrator and HA #124 further confirmed the personal health information of residents #011 and #007 had not been protected. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents related to the security of the bed mattress.

During resident observations and interviews, the inspector observed several identified rooms in which residents' mattresses were found to be sliding off the bed.

Interviews and observations conducted with the home's MM and Director of Nursing (DON) confirmed that the seven beds identified above did not have mattress keepers and posed a safety risk for the residents. [s. 5.]

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

Findings/Faits saillants :

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

A complaint was received by the MOHLTC on an identified date, related to the improper monitoring of a specified test for resident #027.

A review of resident #027's progress notes and plan of care revealed the resident had

cognitive and physical impairments. The resident was sent to hospital on an identified date, because he/she was unresponsive.

Record review of the progress notes and assessment records, along with interviews with Registered Nurse (RN) #100 and the Registered Dietitian (RD) revealed the resident had a history of inadequate intake since admission. The resident #027 was monitored for a specified condition.

A review of physician's orders revealed the physician ordered a dietary supplement for the resident three times a day. A review of the RD's quarterly summary, Food Services Assessment for a specified date, indicated that resident #027 did not receive a nutritional supplement. A review of the Resident Assessment Protocol – Minimum Data Set (RAI-MDS) assessments on an identified date, indicated the resident received a dietary supplement.

A review of the Electronic Medication Administration Records (E-MAR) for a duration of four months and interviews with RN #100 and the Food Services Supervisor (FSS) indicated the dietary supplement had been given to the resident during the above mentioned period three times a day and the resident had refused five times with in the four month duration.

Interview with the RD indicated that in relation to the resident's medical status and poor intake, the resident would be best monitored by a specified test. The RD did not remember whether he/she had brought this up with the interdisciplinary team for consideration. The RD revealed the Food Services Assessment was completed while he/she was away from the home and therefore confirmed he/she did not collaborate with the staff about whether the resident was receiving a dietary supplement and how to best to monitor resident and therefore the assessments were not consistent with each other. [s. 6. (4) (a)]

2. The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health & Long-Term Care (MOHLTC). The CIS report indicated resident #042 was found on last rounds, by Registered Nurse (RN) and Personal Support Worker (PSW) to be trapped in the resident's personal equipment. The resident was transferred to hospital for further assessment for his/her injuries.

An interview conducted with RN #118 indicated resident #042 was able to utilize an identified resident personal equipment for turning and repositioning in the past but

resident was unable to assist with turning and repositioning prior to the incident due to deterioration.

Interview with the DON indicated resident #042 used an identified resident personal equipment and was unaware resident #042 was unable to assist with turning and repositioning when in bed. The DON confirmed staff did not collaborate with the DON in the assessment of resident #042's bed mobility . [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health & Long-Term Care (MOHLTC). The CIS report indicated resident #042 was found on last rounds, by Registered Nurse (RN) and Personal Support Worker (PSW) to be trapped in the resident's personal equipment. The resident was transferred to hospital for further assessment for his/her injuries.

An interview with RN #118 indicated he/she worked on an identified day and shift, with a part-time PSW. The RN stated he/she carried out second night rounds at an identified time, with the PSW, and resident #042 was positioned on his/her right side. The RN stated when he/she went back with the PSW for third rounds and resident #042 had rolled on his/her back and observed the resident was trapped in the resident's personal equipment. The RN further indicated the resident could move himself/herself in the past but was not able to move himself/herself recently due to deterioration and was not sure how he/she got himself/herself trapped in the resident personal equipment. The RN went on to state resident was in pain as the resident was being released from the resident personal equipment and observed cyanosis in identified areas of the resident's body and the resident had sustained injuries which needed further assessment and was transferred to hospital.

Review of the written plan of care dated November 11, 2015, indicated under focus resident was dependent on staff for assistance for identified activities of daily living characterized by the following functions; positioning, locomotion/ ambulation related to: Loss of muscle strength & flexibility, and unstable health condition. An intervention specified to use resident personal equipment all times for positioning as the resident personal equipment where used by the resident to turn or to lift head.

An interview with the DON indicated he/she was unaware resident #042 had deteriorated and was unable to use the identified resident personal equipment for mobility needs. The DOC and Administrator further confirmed the plan of care was not updated with resident's current mobility needs. [s. 6. (10) (b)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

A review of resident #002's plan of care revealed the resident has physical and cognitive impairments and was at risk for falls. Further review of the plan of care revealed the resident had the following fall prevention interventions in place that were created or revised in January and February 2014:
- Encourage resident to use handrails or assistive devices properly
- Ensure environment is free of clutter
- Ensure washroom floor is clean and dry
- High/low bed and mattress on floor as appropriate
- Ensure resident to wear proper and non-slip footwear
- Show resident where her call bell is when she is in bed/her room or washroom, and encourage her to use it if she needs assistance; and
- Transfer and Change positions slowly.

A review of resident #002's progress notes revealed the resident fell on six identified dates and sustained injuries from three of the falls.

Interviews with PSW #108 and RN #100 indicated the resident was at risks for falls and had multiple falls in on an identified month. The staff members confirmed the care set out in the plan of care for the resident's fall prevention had not been effective and the resident kept falling in an identified month. RN #100 and the DON confirmed the plan of care for the resident's fall prevention was not reviewed and revised as care set out in the plan had not been effective. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure;
-that staff and others involved in different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
-that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary,
-that the plan of care is reviewed and revised when care set out in the plan has not been effective, 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 residents were protected from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation,"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

The home submitted a CIS report on an identified date to the MOHLTC. The CIS report was an allegation of staff to resident neglect related to continence care for residents #004 and #045.

Interview conducted with RN #100 indicated he/she worked and identified shift on an identified date and on first rounds found resident #004 to be unsettled in bed. RN stated he/she got a PSW #127 to assist in changing resident #004. RN further stated the brief worn by resident #004 was noted to be dry but found dried feces on resident's peri-area, staff provided resident #004 with peri-care and a new incontinent product was applied.

RN further stated resident #045 was found to be coming out of bed and decided to freshen up resident to help settle to bed. RN stated the brief on resident #045 was noted to be dry but found dried feces in resident's peri-area. Resident was provided with peri-care and a new incontinent product was used. RN identified that he/she informed the Director of Nursing (DON) the next morning during shift change. RN#100 indicated resident #004 and resident #045 were neglected, as proper peri-care was not provided to the residents on evening shift.

Attempts to contact PSW#128 was unsuccessful.

An interview with the home's DON indicated the home conducted an investigation and the evening PSW #128 was terminated for resident neglect. DON confirmed the act of not providing proper peri-care for resident #004 and #045 was neglectful by the staff of the home. [s. 19. (1)]

2. The licensee has failed to ensure that the all residents are protected from verbal abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident, or
(b) any from of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

The home submitted a CIS report and an identified date to the MOHLTC, indicating an identified PSW had made inappropriate statements multiple times and the PSW refused to provide his/her name when the resident asked. The CIS further indicated that the resident had been observed by an identified RN as being upset.

An interview with RN #120 revealed that on an identified date, during his/her second night of orientation he/she had assisted PSW #105 to provide care to resident #057. The RN revealed that at 0100 hrs, resident #057 had rang his/her call bell for assistance and he/she initially responded to the call. The RN further revealed that resident #057 had been found lying in his/her bed with bed linen soaked in urine. Within minutes the RN stated that PSW #105 entered the room and in a loud voice repeatedly made inappropriate statements to resident #057. The RN indicated that the resident became very upset and wanted to know the PSW's name. The PSW would not provide his/her name, however, stated a different PSW's name to the resident. The RN continued to state that he/she found the incident to be severe and indicative of emotional abuse as the resident became very upset at what the PSW had been saying to him/her.

An interview with PSW #105 confirmed he/she had provided care to resident #057 during and identified shift on an identified day, along with RN #120. The PSW indicated that resident #057 was found lying in bed wet with continence care product open and that resident #057 had been upset for being incontinent. When asked if PSW #105 had made inappropriate statements, PSW #105 responded that he/she had made the above mentioned statement at the nursing station to RN #118 and not in front of the resident.

An interview with RN #118 revealed that he/she had no recollection of PSW #105 discussing the above comment at the nursing station.

An interview with resident #057 did not reveal any recollection of the above mentioned incident. As a result, the inspector reviewed the home's investigation notes which revealed that resident #057 had been upset on an identified date, when PSW #105 did not provide his/her name to the resident when the resident had asked.

An interview with the DON indicated the above allegation was reported to him/her by the RN #100, on an identified date and the immediately began an internal investigation. As a result of the home's investigation the DON confirmed that the above mentioned incident was verbal abuse and that PSW #105 received a one day suspension. [s. 19. (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
-residents were protected from neglect by the licensee or staff in the home
-the all residents are protected from verbal abuse, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of resident #002's plan of care and progress notes revealed the resident was at risk for falls. The resident fell on an identified date and sustained no injury. A review of the home's policy entitled "Falls Prevention Program", revised in January 2016, indicated the home uses a "Risk Incident Management" (RIM) assessment in Point Click Care (PCC) to assess a resident after each fall. A review of resident #002's assessment record indicated a post-fall assessment had not been completed for the resident.

Interviews with RN #100 and the DON indicated the post-fall RIM assessment should have been completed for resident #002 after each fall. RN #100 confirmed resident fell on an identified date, and a post-fall assessment had not been conducted using the RIM assessment as required. [s. 49. (2)]

2. A review of resident #010's plan of care and progress notes revealed the resident had cognitive and physical impairments and was at risk for falls. On an identified date, the resident was found sitting on a staff chair in an identified location of the home, and he/she slipped and fell from the chair, the resident sustained no injury from the fall.

A review of the home's policy entitled "Falls Prevention Program", revised in January 2016, indicated the home uses a RIM assessment in PCC to assess a resident after each fall.

A review of resident #010's assessment records indicated and interview with RN #100 confirmed a post-fall assessment had not been completed for the resident as required. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 108. Misuse of funding
For the purposes of paragraph 5 of subsection 24 (1) and paragraph 6 of subsection 25 (1) of the Act, "misuse" of funding means the use of funding provided by either the Ministry or a local health integration network,
(a) for a purpose other than a purpose that was specified as a condition of the funding; or
(b) in a manner that is not permitted under a restriction that was specified as a condition of the funding. O. Reg. 79/10, s. 108.

Findings/Faits saillants :

1. The licensee has failed to ensure that funding provided by either the Ministry or a local health integration network, was not misused.

For the purposes of paragraph 5 of subsection 24 (1) and paragraph 6 of subsection 25 (1) of the Act, "misuse of funding means the use of funding provided by either the Ministry or a local health integration network, (a) For a purpose other than a purpose that was specified as a condition of the funding.

The home submitted a CIS report on an identified date to the MOHLTC indicating a former employee had used the home's Staples credit card for unauthorized purchases in the amount of $21, 452.85, from 2012 to 2014.

An interview with the home's current Administrator revealed that during the month of

September 2014, he/she had assisted the previous Administrator to allocate and reconcile the home's accounts payable invoices. The Administrator indicated that while reconciling the Staple's statements for the months of April, May, June and August 2014, he/she noticed that purchases had been made using a credit card with the last four digits being different than what the home normally had used, prompting the home to investigate.

The Administrator indicated that from April 2012 to August 2014, a total of $21,371. 30, in mixed plus Visa gift cards had been purchased at Staples, using the home's Staples credit card. The Administrator confirmed that none of the mixed plus Visa gift cards purchased had been provided to the home for resident use and that he/she had never seen or had been aware that gift cards had been purchased. The Administrator further confirmed that all of the Staples purchases had been purchased by the home's former employee who had been provided the home's Staples credit card to conduct supply purchases for the home as a responsibility of his/her role.

The Administrator revealed that the former employee had worked at the home since 2006, until his/her resignation in February 2014. The Administrator indicated that the former employee had returned the Staples credit card at the time of his/her resignation, however, retained a secondary credit card that he/she continued to use for the months of April, May, June, and August 2014, which had been unknown to the home.

The Administrator confirmed that the former employee has been charged by police for forgery, fraud, impostering and a court date is pending. The Administrator further confirmed that a total of $21,371.30, had been misused by the home, the funds that had been provided by the local health integration network for resident accommodation from April 2012 until August 2014. [s. 108.]

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 funding provided by either the Ministry or a local health integration network, was not misused, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

On an identified date, during resident observations on an identified floor and two identified residents room the window next to resident #002 and resident #009's bed was opened to the garden in full, wider than 15 centimeters (cm) and was missing the window stopper at the crank of the window.

This inspector conducted observation in the adjoining rooms on the identified floor and no concerns were found related to window openings.

Observations and interviews conducted with Maintenance Manager (MM) and DON confirmed the windows identified above opened more than 15 cm which posed a safety risk to residents in the shared room and did not meet legislation. [s. 16.]

WN #9: 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 drugs were stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On an identified date, on an identified floor while conducting the narcotic bin audit the inspector observed the following items to be stored in the narcotic bin of the medication cart: bus tickets, four envelopes of money to be given to families and administrator, envelope with money for the Mandarin trip, and money being held for resident #046.

An interview conducted with RPN #110 indicated the home stores residents' money and belongings in the narcotic bin or medication cart for security purposes, as there is no alternative place to store them.

Interview with the DON revealed that the above mentioned items should not be stored in the medication cart narcotic bin and will be removed immediately. [s. 129. (1) (a)]

Issued on this 17th day of October, 2016

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHIHANA RUMZI (604), JENNIFER BROWN (647), MATTHEW CHIU (565), VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2016_268604_0013
Log No. / Registre no:	012651-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 23, 2016
Licensee / Titulaire de permis :	PORANGANEL HOLDINGS LIMITED 2231 MEDHAT DRIVE, MISSISSAUGA, ON, L5B-2E3
LTC Home / Foyer de SLD :	KING CITY LODGE NURSING HOME 146 Fog Road, King City, ON, L7B-1A3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Shellie Hill

To PORANGANEL HOLDINGS LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

Within one week of receipt of this order, provide a plan to the inspector by being September 30, 2016:

1) How the home will ensure that all residents utilizing bed rails will be assessed and his or her bed system will be evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents.

2) What steps will be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

3) What other safety issues related to the use of bed rails will be addressed, including height and latch reliability.

The plan shall be submitted to shihana.rumzi@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident

entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health & Long-Term Care (MOHLTC). The CIS report indicated resident #042 was found on last rounds, by Registered Nurse (RN) and Personal Support Worker (PSW) to be trapped in the resident's personal equipment. The resident was transferred to hospital for further assessment for his/her injuries.

An interview with RN #118 indicated he/she worked on an identified day and shift, with a part-time PSW. The RN stated he/she carried out second night rounds at an identified time, with the PSW, and resident #042 was positioned on his/her right side. The RN stated when he/she went back with the PSW for third rounds and resident #042 had rolled on his/her back and observed the resident was trapped in the resident's personal equipment. The RN further indicated the resident could move himself/herself in the past but was not able to move himself/herself recently due to deterioration and was not sure how he/she got himself/herself trapped in the resident personal equipment. The RN went on to state resident was in pain as the resident was being released from the resident personal equipment and observed cyanosis in identified areas of the resident's body and the resident had sustained injuries which needed further assessment and was transferred to hospital.

An identified home's policy with a revised date of May 25, 2015, indicates under standards #2: The need for resident personal equipment to be reassessed with any changes in the resident's status or at least quarterly to reduce the risk of harm to residents.

Minimal Data Systems (MDS) assessment dated October 29, 2015, indicated in section "P" special treatments and procedures, the resident utilized identified resident personal equipment for daily care.

The written plan of care dated November 11, 2015, indicated resident #045 utilized identified resident personal equipment for positioning.

A review of the home's January 2015, an identified assessment indicated the personal equipment was assessed. This was contrary to what RN #118

indicated, which was that resident #042 did utilize identified resident personal equipment all the time. When interviewed the Maintenance Manager (MM) indicated he/she is unaware if an identified assessment being conducted specifically to assess resident #042 and possible areas of risk and further indicated only the equipment was assessed.

Interviews conducted with the DON and Administrator confirmed that resident #042 was trapped in an

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

The home submitted a Critical Incident System (CIS) report on an identified date, to the Ministry of Health & Long-Term Care (MOHLTC). The CIS report indicated resident #042 was found on last rounds, by Registered Nurse (RN) and Personal Support Worker (PSW) to be trapped in an identified residents personal equipment. The resident was transferred to hospital for further assessment for his/her injuries.

An interview with RN #118 indicated he/she worked on an identified day and shift, with a part-time PSW. The RN stated he/she carried out second rounds at an identified time, with the PSW, and resident #042 was positioned on his/her right side. The RN stated when he/she went back with the PSW for third rounds and resident #042 had rolled on his/her back and observed the resident was trapped in the identified residents personal equipment. The RN further indicated the resident could move himself/herself in the past but was not able to move himself/herself recently due to deterioration and was not sure how he/she got himself/herself trapped in the resident personal equipment. The RN went on to state resident was in pain as the resident was being released from the identified resident personal equipment and observed cyanosas on an identified area of the resident's body and the resident had sustained injuries which needed further assessment and was transferred to hospital.

An identified home's policy with a revised date of May 25, 2015, indicates under

standards #2: The need for resident personal equipment to be reassessed with any changes in the resident's status or at least quarterly to reduce the risk of harm to residents.

Minimal Data Systems (MDS) assessment for a specified date, indicated the resident utilized identified resident personal equipment for daily care.

The written plan of care for a specified dated indicated resident #045 utilized the identified resident personal equipment for positioning.

A review of the home's January 2015, bed assessment an identified assessment indicated the identified personal equipment was assessed and not for the use of resident #042's needs. This was contrary to what RN #118 indicated, which was that resident #042 did utilize identified resident personal equipment all of the time. When interviewed the Maintenance Manager (MM) indicated he/she is unaware if an identified assessment being conducted specifically to assess resident #042 and possible areas of risk and further indicated only the equipment was assessed.

Interviews conducted with the DON and Administrator confirmed that resident #042 was trapped in an identified resident personal equipment and sustained injuries which needed further assessment and had to be transferred to hospital. The DON and Administrator confirmed resident #042 had not been assessed for the use of the resident personal equipment and resident personal equipment had not been evaluated in accordance with evidence-based practices to minimize risk for resident #042.

The inspector found the home had failed to ensure that resident #042's individual resident personal equipment was assessed and the residents personal equipment system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident whereby steps were taken to prevent resident risk, taking into consideration all potential areas of risk and other safety issues related to the use of the identified resident personal equipment where addressed. As a result, resident #042 sustained actual harm when the resident got trapped in the identified resident personal equipment.

The severity of the non-compliance and the severity of harm and risk is actual harm as resident #042 sustained injuries which needed further medical

assessment and was transferred to hospital.

The scope of the non-compliance is isolated.

A review of the home's past compliance history revealed non-compliance related to the Long-Term Care Homes Act, O.Reg 79/10, s. 15. (1). A voluntary plan of correction (VPC) was previously issued under O.Reg 79/10, s. 15. (1) (c) during a Resident Quality Inspection (RQI) issued to the home on January 29, 2015, under Inspection # 2015_340566_0002.
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

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 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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shihana Rumzi

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