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 sions 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
May 19, 2016	2016_251512_0004	T-1404-14	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 16, 17 & 18, 2016.

This inspection is related to two critical incidents reported to the Ministry of Health and Long-Term Care (MOHLTC). A complaint was also received related to the same incidents. Intake number: T-1404-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of care (ADOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident, and power of attorney of resident.

During the course of the inspection, the inspector conducted observations in home and resident area, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

An identified critical incident (CI) report was received by the Ministry of Health and Long-term Care (MOHLTC) of a resident to resident incident which occurred in the home on an identified date which involved resident #001 and #002. The incident occurred on the main level of the home where resident #001 was observed hitting resident #002 in an identified part of his/her body. No obvious injuries were noted in the two residents.

A second identified CI report was submitted to the MOHLTC of another resident to resident incident occurred five months after the first identified report, which involved the same two residents. The incident occurred in the main lobby of the home where resident #002 was observed to be verbally abusive to resident #001. Resident #001 retaliated by physical aggression towards resident #002. There were no obvious injuries to the two residents noted in this incident.

Interviews with resident #001, an identified family member of resident #002, PSWs, and RPNs, indicated resident #001 was verbally and physically abusive to co-residents, especially towards resident #002.

Review of resident #001's progress notes revealed 11 episodes of physical or verbal aggression demonstrated by the resident towards other residents and staff for a period of 17 months. Review of resident #001’s written care plan revealed some interventions were set up to address the resident's verbal and physical aggression. The resident’s care plan was noted last revised on an identified date, with no new interventions to manage the resident’s aggressive behavior as evidenced by the list of continuous aggression since the identified date.

Interview with the ADOC indicated that resident #001 had been followed up by an identified community behavioral management agency. However the resident had refused to provide consent for further consultation. The home implemented an identified intervention for resident #001 for a period of time after the resident demonstrated increased aggressive behavior. The intervention was discontinued when resident #002 was transferred to another long term care home and resident #001's aggressive behavior had decreased. Interview with the Executive Director stated that the home had done all

they could to manage resident #001's aggressive behavior. The ED confirmed that there was nothing else that the home could have done to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff receive the required training annually to manage responsive behaviors in residents.

Record review indicated that in 2015, 63 per cent of the home's PSWs, RNs and RPNs received responsive behavior management training by attending in-service sessions and by accessing the home's electronic learning modules.

Interviews with two RPNs and two PSWs involved with the care of residents exhibiting responsive behaviors indicated one of the PSW did not receive training on responsive behaviors in 2015.

Interview with the ADOC and the ED confirmed that 37 per cent of all direct care staff did not receive the required training in 2015 to manage responsive behaviors in residents. [s. 221. (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 all direct care staff receive the required training annually to manage responsive behaviors in residents, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Interview with resident #001 revealed the resident has been going out of the building and across the street at least two to three times a day every day. The resident ambulated himself across the street. The resident was aware that he/she was supposed to sign in and out on a log at the front entrance whenever he/she goes out of the building and upon returning. During the interview, the resident admitted to the inspector that he/she had never signed in and out on the log.

Interviews with PSW #104 and RPN #105 indicated the resident went out several times a day without informing nursing staff on the unit. PSW #104 indicated that at times staff would be looking for the resident to find out that he/she was not in the building. Interview with RPN #108 revealed the resident was aware he/she was supposed to sign in the leave of absence (LOA) binder on the unit prior to leaving the floor. However, the resident would refuse to do so. The PSWs and RPNs interviewed indicated there were no clear directions in the written care plan regarding the resident's daily leave of absences.

The resident's current written care plan was reviewed. There was no indication of any focus, goals and interventions set up to address the resident's daily leave of absences.

Interviews with the ADOC and the Executive Director confirmed that the resident's daily LOA should be included in the written plan of care to provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that if a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone that resulted in harm or risk of harm.

Review of an identified critical incident (CI) report indicated a resident to resident suspected verbal and physical abuse occurred on an identified date. The CI report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) nine days after the occurrence date. Record review indicated no evidence of any report made to MOH immediately by using the after hours reporting phone line.

Interview with the Executor Director confirmed that the CI report of suspected abuse was submitted to the MOHLTC nine days after the critical incident occurred, and not submitted as immediate as required by legislation. [s. 24. (1)]

Issued on this 11th day of July, 2016

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

Original report signed by the inspector.