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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_630589_0015	007919-17, 008314-17, 008469-17, 013957-17, 014235-17, 014343-17, 015486-17, 016911-17, 019369-17	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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), VERON ASH (535)

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): September 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 27, and 28, 2017.

The following critical incident reports (CIR) were inspected during this inspection:
-log #008314-17(CIR #2789-000031-17) related to alleged abuse,

-log #013957-17 (CIR #2789-000055-17) related to responsive behaviour and alleged abuse,
-log #015486-17 (CIR #2789-000059-17) related to responsive behaviours and abuse,
-log #019369-17 (CIR #2789-000067-17) related to prevention of abuse and neglect,
-log #008469-17 (CIR #2789-000033-17) related to falls prevention, and
-log #'s 014343-17 (CIR #2789-000053-17), and #014235-17 (CIR #2789-000051-17) related plan of care and falls prevention.

This inspection was conducted concurrently with three complaint inspections and a follow-up inspection.
The follow-up inspection #2017_324535_0014/log #008040-17, #011346-17, and #011347-17, also included critical incident reports (CIR), log #007919-17 (CIS #2789-000039-17), and log #0169911-17 (CIS #2789-000065-17) related to O. Reg. 79/10, r. 36.

The complaint inspection reports included the following reports:
-#2017_632502_0013/log #008060-17, #012087-17,
-#2017_632502_0014/log #008181-17, #010356-17 (CIR #2789-000045-17), #021526-17, and
-#2017_632502_0016/log #023111-17.

Findings of non-compliance related to LTCH Act, 2007, s. 6. (10) (c), identified in inspection #2017_324535_0014/log #008040-17, 011346-17, and 011347-17, will be issued in this report.
Findings of non-compliance related to LTCH Act, 2007, s. 6. (5), s. 6. (10) (b), and O. reg. 79/10, r. 107 (4) 3, identified in inspection #2017_632502_0013/008060-17, and 012087-17, will be issued in this report.
Findings of non-compliance related to LTCH Act, 2007, s. 6. (7), and s. 6. (1) (a), identified in inspection #2017_632502_0014/008181-17, 010356-17 (CIR #2789-000045-17), and #021526-17, will be issued in this report.
Findings of non-compliance related to LTCH Act, 2007, s. 6. (4) (a), identified in inspection #2017_632502_0016/023111-17, will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), interim Executive Director (I-ED), Director of Care (DOC), interim Director of Care (I-DOC), Associate Director of Care (ADOC), former Associate Director of Care (f-ADOC), Physician, Registered Nurses (RN), Registered Practical nurse (RPN),

Personal Support Workers (PSW), Physiotherapist (PT), Nursing Rehabilitation Coordinator (NRC), Director of Food Services (DFS), Nurse Managers (NM), Ward Clerk (WC), Scheduling Clerk (SC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS-C) coordinator, Residents, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) conducted a tour of the home and of the outside garden area, observations of staff to resident interactions and the provision of care, record review of health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 VPC(s)**
- **3 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 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).

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC)

related to an incident of alleged abuse. Review of the complaint revealed that resident #002 had requested assistance with care several times in an identified period of time. Further review of the complaint revealed that staff #114 was unavailable even after staff #100 had directed him/her to assist the resident.

Review of an assessment completed on an identified date in January 2017, revealed that resident #002 was cognitively intact. Further review of this assessment revealed that resident #002 required frequent assistance with care, which required the assistance of one staff.

Review of resident #002's most recent written plan of care revealed that resident #002 only required care with the use of a continence care product. Further review of the written plan of care revealed that staff are to provide assistance with care at identified times in a shift. Further review of the written plan of care failed to reveal a plan of care which indicated that the resident was able to ask for assistance, and that no schedule had been implemented to ensure that the resident remained free of incontinence episodes.

In an interview, resident #002 stated that he/she requires assistance with care at identified times and staff expect him/her to call for assistance as needed. Resident #002 further stated that on an identified date in April 2017, he/she requested assistance with care from staff #114, on three identified occasions and was not assisted. Resident #002 stated at this time, that the continence care product was saturated and accumulating on the foot pedals of the mobility aid. Resident #002 stated that he/she did not request assistance from another staff, as the home was short staffed.

Resident #002 also stated that since the above mentioned incident, two staff are to be present for all of his/her care, which usually takes an additional amount of time before he/she is provided assistance with care needs. As result, resident #002 stated that his/her continence care product is usually saturated resulting in repeated changes of clothing every day and the developed of a persistent area of altered skin.

In interviews, staff #114, #135, and #138 stated that resident #002 experiences frequent episodes of soiled continence care products and whenever he/she requests assistance, he/she is already heavily soiled.

In interviews, staff #100 and #133 stated that resident #002 was cognitively intact, able to call for assistance as needed; however, both staff stated that resident #002 did not have an individualized continence care plan.

Staff #165, who is also the continence care program lead confirmed that resident #002 did not had an individualized continence care plan, as he/she was able to request for assistance as needed.

PLEASE NOTE: This evidence of non-compliance for resident #002 was found during inspection #2017_632502_0014. [s. 6. (1) (a)]

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

A complaint was submitted to the MOHLTC related to improper care of resident #008. Review of the complaint revealed that during a care conference on an identified date in September 2017, resident #008's family voiced concerns to staff that they had noticed a decline in resident #008's responsive behaviours.

Review of an assessment completed revealed that resident #008 was admitted to the home with cognitive impairment. During the time of this inspection, the resident was transferred out of the home for assessment and treatment related to an incident of responsive behavior. Record review revealed that from the time of admission to the home, the resident had demonstrated identified responsive behaviours.

During separate interviews, staff #197, #108 and #199 confirmed that they were aware of resident #008's responsive behaviors; and staff #108 and 199 confirmed that the behavior appeared to be more prominent during the evening shift. In an interview, staff #196 confirmed that resident #008 demonstrated responsive behaviors; however, he/she had not discussed these responsive behaviours with the home's behavioral team, nor complete a behavioral assessment. According to the staff, the resident home area had a recent turnover in nurse manager, therefore the discussion related to the resident's behaviors and referral support was missed.

In interviews, staff #156 and staff #122 stated that they were unaware of resident #008's responsive behaviors until an identified date in September 2017. Staff #122 stated that registered staff should have followed the home's protocol, which was to discuss the resident's responsive behaviors with the physician, contact the family to obtain consent for the referral, and obtain an order for a referral to external resources.

Furthermore, a review of this case revealed that staff involved in the different aspects of resident #008's care did not collaborate with each other in the assessment of the resident to provide consistent and integrated care.

PLEASE NOTE: This evidence of non-compliance for resident #008 was found during inspection #2017_632502_0016. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the developments and implementation of the plan so that the different aspects of care are integrated and are consistent with and complement each other.

A CIR was submitted to the MOHLTC, for an incident involving resident #033. The CIR revealed that resident #033 had been provided morning care and settled back into bed by staff #154. When staff #154 left the room to assist another resident he/she heard a noise. Upon investigating staff #154 found resident #033 had experienced an incident in another resident's room. Resident #033 was transferred to hospital for an assessment of an injury sustained in the above mentioned incident.

Review of the transfer notes revealed the physician had recommended a specific consultation as an outpatient and had included a completed referral note. Review of resident #033's health record revealed under the physician's order tab that an order had been written by resident #033's primary physician for this consultation.

Review of resident #033's electronic documentation notes revealed that a consultation appointment had been booked, but was cancelled by a family member. The documentation notes further revealed that the family member was to call the LTCH back with the date of the re-booked appointment. At the time of this inspection, the appointment had not been rebooked.

In an interview, staff #155 stated that he/she should have documented in the 24 hour report for staff to follow-up with resident #033's family and also should have reported to the fourth floor manager that family had cancelled resident #033's the appointment and had not called the LTCH back with a new date and time for the appointment.

In an interview, staff #107 acknowledged that staff had failed to follow-up regarding the re-booking of the appointment with family and therefore had not collaborated with each other in the developments and implementation of the plan.

4. A CIR was submitted to the MOHLTC, for an incident involving resident #033. The CIR revealed that resident #033 had been provided morning care and settled back into bed by staff #154. When staff #154 left the room to assist another resident he/she heard a noise. Upon investigating staff #154 found resident #033 had experienced a fall in another resident's room. Resident #033 was transferred to hospital for an assessment of an injury sustained in the above mentioned incident.

Review of the most recent written plan of care revealed staff #107 had revised the interventions to include time identified safety checks to be completed. The CIR also revealed the same above mentioned intervention under the immediate actions section of the report.

Review of the point of care electronic documentation system (POC) from an identified period of time to the current inspection time frame revealed that identified safety checks had not been documented.

In an interview, staff #154 stated that the POC had not indicated the above mentioned and therefore he/she had not documented that this had been completed. Staff #154 further stated that only in the last week and a half had this intervention been added to the POC.

In an interview, staff #107 stated that he/she had not audited for the completion of this intervention as he/she expected the staff to have completed them as indicated in the care plan. Staff #107 was not able to provide documentation from the POC; only providing that alternate reports had been completed

Staff #107 acknowledged that staff had not collaborated with each other in the implementation of the plan of care for resident #033. [s. 6. (4) (b)]

5. A CIR was submitted to the MOHLTC, which revealed that resident#034 was transferred to hospital on a specified date related to a change in his/her physical health status.

Review of the health institution's transfer notes which included two revealed two new health conditions.

Review of resident #034's health record in PCC under the medical diagnosis tab did not

reveal the above two health conditions had been added after his/her re-admission to the home.

In an interview, staff #148 stated he/she had not seen the two transfer notes and therefore was not aware of the new health conditions. Staff #148 further stated he/she would send a referral to the registered dietician (RD) related to one of the new health conditions.

In an interview, staff #150 stated the home had not received discharge notes for resident #034 upon his/her re-admission to the long term care home (LTCH) on and that he/she had to request them from the health institution. Upon receiving the discharge notes for resident #034, staff #150 stated he/she had them in his/her possession and could not recall if he/she had given a copy to resident #034's home areas registered staff and physician. As a result, staff #150 acknowledged that staff and others involved in the different aspects of care had not collaborated with each other in the developments and implementation of the plan. [s. 6. (4) (b)]

6. A CIR was submitted to the MOHLTC related to an incident that occurred between two residents. The CIR revealed that resident #038 had demonstrated a responsive behaviour towards resident which resulted in an injury to resident #038. The CIR further revealed a referral had been completed related to resident #037's demonstration of responsive behaviours and that the referral was pending.

Review of an assessment completed for resident #037 revealed memory impairment and impaired memory recall and orientation with poor decision making and cues or supervision required. Review of the written plan if care at the time of the above mentioned incident revealed identified responsive behaviours demonstrated by resident #037. Further review revealed a referral had been completed to the home's internal behavioural team.

Review of resident #037's documentation notes revealed that staff #168 had completed a follow-up response to the referral. The follow-up response included an assessment of medication, most recent RAI-MDS scores and a plan to trial resident #037 on another floor.

In an interview, staff #168 stated the social worker in the home had shown resident #037 an alternate room on another floor and that he/she had refused to move. Staff #168 further stated that he/she thought that staff #107 had been aware however could not

confirm definitively that staff #107 had been informed of trialing resident #037 on another floor.

In an interview, staff #107 who is in charge of an identified floor where resident #037 resides acknowledged that he/she was not aware of any trial to move resident #037 to another floor.

The severity of this incident is actual harm/risk sustained by residents. The scope is identified as a pattern.
The home failed to collaborate with each other in the provision of care related to a neurology appointment and in the provision of nightly hourly safety checks for resident #033. The home also failed to collaborate with each other in the development and implementation of the plan for resident #034 and failed to protect resident #038 from harm as a result of a resident to resident altercation with resident #037.
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC) under s. 6. (4) (b) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6., Plan of Care, a compliance order is warranted. [s. 6. (4) (b)]

7. The licensee has failed to ensure that the resident, the resident's substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the MOHLTC related to an injury of unknown cause involving resident #003. Review of the complaint revealed that on an identified date in June 2017, resident #003's SDM had visited the resident and found him/her in bed as he/she with impaired mobility. The SDM reported the concern to nursing staff which resulted in an x-ray being ordered. Subsequently, the x-ray resulted in the diagnosis of an injury and a transfer to an alternate health institution.

Review of resident #003's written plan of care at the time of the incident revealed that resident #003 had underlying physical health conditions that contributed to mobility impairments.

In an interview, staff #144 stated that he/she had not informed the family about resident #003's change in health status even though staff #181 had reported to him/her that resident #003 had concerns with mobility and comfort.

In an interview, staff #100 stated that resident #003 was experiencing impaired mobility and had directed the PSWs to keep the resident in bed and provide all activities of daily living (ADLs) in bed. Staff #100 confirmed that when resident #003's condition had changed, he/she had not communicated this change with the resident #003's substitute decision maker (SDM).

In an interview, family member (FM) #200, who is also resident #003's SDM, told the inspector that he/she was not aware that resident #003 had experienced a change in their health status until he/she visited on an identified date in June 2017.

In interviews, staff #111 acknowledged that registered staff should have notified resident #003's SDM when there had been a change in his/her health status. Staff #150 confirmed that resident #003's SDM was not provided the opportunity to fully participate in the implementation of resident #003's plan of care

PLEASE NOTE: This evidence of non-compliance for resident #003 was found during inspection #2017_632502_0013. [s. 6. (5)]

8. The licensee has failed to ensure the care set out in the plan of care is provided to resident #034 as specified in the plan.

A CIR was submitted to the MOHLTC which revealed that resident #034 was transferred to hospital related to a change in his/her health status. The CIR also revealed that resident #034 had been admitted with identified health condition. The CIR further revealed that resident #034s substitute decision maker (SDM) called the home on an identified date in August 2017, to inform staff #150 that resident #034 had also been diagnosed with an injury.

Review of resident #034s written plan of care at the time of the incident revealed he/she was at risk for incidents related to periods of changes in his/her health status and cognitive impairment. Further review of the written plan of care revealed that resident specific interventions were to be in place.

Resident #034's written plan of care completed on an identified date in August 2017, which was completed after the above mentioned incident revealed the same interventions as identified above.

Observations by the inspector revealed resident #034 had all of the specified interventions in place except for one. Review of the point of care (POC) flow sheets revealed that staff #114 had documented that this identified intervention had not been applied on an identified date in September 2017.

In an interview, staff #114 stated that when he/she had worked on an identified date in September 2017, this intervention was not in place and that he/she had not reported this to the registered staff at the time because he/she thought resident #034 did not require it any more. PSW #114 also stated that on the next two days this intervention had also not been in place.

Further observations by the inspector revealed the identified intervention had been re-applied to resident #034's bed, three days later.

In an interview, staff #117 stated that after staff #114 had been interviewed by the inspector he/she had reported that resident #034 required an identified intervention to be in place, which staff #117 then applied.

In an interview, staff #111 acknowledged that resident #034 did not have the identified intervention in place for three days and therefore the care set out in the plan of care was not provided to resident #034 as specified in the plan. [s. 6. (7)]

9. A complaint was submitted to the MOHLTC related to improper care provided to resident #002. Review of the complaint revealed that the home failed to properly document resident #002's known underlying health conditions in resident #002's plan of care.

In an interview, resident #002 stated that a nursing staff inserted an improper continence device that resulted in altered skin integrity to an identified area of resident #002's body. Resident #002 stated that staff #124 assisted him/her in removing the above mentioned device few hours later.

Review of the written plan of care revealed that resident #003 required the use of a continence device related to an underlying health condition. Further review of resident #002's written plan of care revealed that he/she has identified underlying health conditions that require specific interventions related to the use of continence devices.

On an identified date in September 2017, in a medication room, the inspector

observation a box containing continence devices with a disclaimer written on the box, noting a possible reaction if used. Staff #133, who was present during the observation stated that the above mentioned box contained the only available continence devices available in the medication room and that one was used earlier on the same day on resident #002.

In an interview, staff #124 confirmed he/she had removed an identified continence device from resident #002, and believed that may not have been the required continence device for resident #002, however could not confirm this. Staff #124 did confirm that resident #002 had altered skin integrity to an identified body area.

In an interview, staff #100 confirmed that the above identified continence devices had been used previously up to an identified date in September 2017, when resident #002 developed altered skin integrity. He/she stated that since resident #002 had a reaction, alternate continence devices were purchased.

In an interview, staff #111 stated that he/she had ordered the alternate continence devices and was not aware that the supplier had delivered the required continence device until resident #002 developed a reaction. Staff #111 further stated that after resident #002 experienced a reaction, he/she re-ordered the required continence devices, and that resident #002's name had been written on the box to avoid any future mistakes.

PLEASE NOTE: This evidence of non-compliance for resident #002 was found during inspection #2017_632502_0014.

The severity of this incident is actual harm/risk as one resident sustained altered skin integrity and the other resident sustained an injury of unknown cause. The scope is identified as a pattern.
The home failed to protect resident #002 from harm related to an identified health condition response and failed to protect resident #034 from a potential for harm related to not providing care to as specified in the plan.
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC) under s. 6. (7) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6 Plan of Care, a compliance order is warranted. [s. 6. (7)]

10. The licensee has failed to ensure when the resident was reassessed that the plan of

care was reviewed and revised when the care needs changed or care set out in the plan care was no longer necessary.

A CIR was submitted which revealed resident #032 had an incident on the same day which resulted in a transfer to an alternate health institution for assessment. Further review of the CIR revealed that resident #032 had sustained an injury.

Review of the most recent written plan of care revealed that resident #032 used a mobility aid for ambulation and now required supervision for safety as a result of the above mentioned incident.

In an interview, staff #113 stated that resident #032 now required supervision by one staff member when ambulating to the dining room for meals and for continence care.

Observations by the inspector revealed resident #032 ambulating independently with his/her mobility aid from the main dining room to the elevators and then into the elevators.

In an interview, resident #032 stated he/she basically does everything for him/herself, requiring very little assistance from staff.

In an interview, staff #171 stated he/she had completed a reassessment of resident #032 the prior week, however he/she could not identify the exact date. Staff #171 further stated the reassessment had deemed resident #032 capable related to mobility and therefore was to be discharged from the program.

Further review of the most recent written plan of care continued to reveal that resident #032 required supervision when ambulating with a mobility aid.

In a follow-up interview, staff #171 stated he/she had not reviewed and revised resident #032's plan of care at the time of the re-assessment and was planning to update the plan of care right after this interview with the inspector.

In an interview, staff #111 acknowledged the care set out in the plan was no longer necessary for resident #032 and that staff #171 was to have reviewed and revised the plan of care at the time of the reassessment and not a week later. [s. 6. (10) (b)]

11. A CIR was submitted to the MOHLTC for an incident that occurred between two

residents. The CIR revealed that resident #038 had wandered into resident #037's room and that resident #037 demonstrated a responsive behaviour towards resident #038 which resulted in an injury. The CIR further revealed a referral had been completed related to his/her demonstration of responsive behaviours and that the referral was pending.

Review of health record for resident #038 revealed he/she was admitted with identified underlying health conditions, the ability to mobilize without the aid of a mobility aid, and the demonstration of identified responsive behaviours. Further review of resident #038's health record revealed resident specific interventions to be implemented when demonstrating responsive behaviours.

Review of an assessment completed for resident #038 revealed memory impairment that affected memory recall and orientation with poor decision making and cues or supervision required.

Review of health record for resident #037 revealed he/she was admitted with identified underlying health conditions, that he/she ambulated independently without the aid of any assistive aid and demonstrated specific responsive behaviour related to his/her belongings and personal space.

Review of an assessment completed for resident #037 revealed memory impairment which affected memory recall and orientation with poor decision making and cues or supervision required.

Observations by the inspector revealed resident #037 was demonstrating responsive behaviours in the main area by the nursing station towards another resident however, a PSW intervened and was able to calm resident #037 down. Further observations conducted on three identified dates revealed resident #037 was not demonstrating any responsive behaviours.

Review of the written plan of care in place at the time of the above mentioned incident revealed specific interventions to be implemented when responsive behaviours were demonstrated.

Observations conducted during this inspection by the inspector revealed resident #037 participating in scheduled activity programs.

Review of resident #037's documentation notes revealed the resident was assessed on behaviour rounds with new interventions to be implemented.

In an interview, staff #122 acknowledged that resident #037 had been assessed as the care set out in the plan of care had not been effective and that the plan of care had not been reviewed and revised to include the newly discussed action plan. [s. 6. (10) (b)]

12. A CIR was submitted to the MOHLTC related to resident #031 after an incident that had occurred on an identified date in June 2017. The CIR further revealed resident #031 was dependent for mobility, requires one staff assistance with transfers, and often demonstrates responsive behaviours.

Review of resident #031's health record revealed an assessment had been completed on an identified date in August 2017, for the use of a restrictive device when up in the mobility aid. The assessment revealed that alternatives had been in place for over a year and had not been effective.

Observations by the inspector revealed resident #031 had a restrictive device in place that was not the restrictive device that had been identified in the assessment completed.

Review of resident #031's health record failed to reveal that resident #031 had been reassessed for the use of an alternate restrictive device prior to this device being applied.

In an interview, staff #101 stated that the assessed restrictive device had not been delivered so in consultation with staff #122, it was decided to obtain a physician's order for an alternate restrictive device until the assessed restrictive device was available to be applied. Staff #101 further stated that he/she had not completed a reassessment as he/she thought the original assessment that had been completed was sufficient. Staff #101 also stated he/she was aware that the two devices are different and that he/she should have completed a reassessment.

In interview, staff #121 and staff #111 acknowledged that a reassessment for the use of the alternate restrictive device for resident #031 had not been completed prior to application of this device and that the plan of care had not been reviewed and revised when resident #031's care needs changed.
[s. 6. (10) (b)]

13. While conducting an inspection in the home, resident #001 made a direct complaint of inappropriate care to the inspector related to a specific incident.

Record review revealed that resident #001 had an assessment completed that revealed he/she was independent and a reasonable decision-maker. The assessment also assessed the resident with altered mobility all or most of the time, with no mode of transportation listed. However, a review of resident #001's plan of care revealed that the resident used a mobility aid independently as their primary mode of locomotion.

The inspector observed that resident #001 was unable to independently mobilize him/herself since readmission from an alternate health institution in August 2017.

During an interview, staff #102 confirmed that resident #001 was currently inactive and waiting on a specialized mobility aid. He/she also stated that there was no current plan in place to mobilize the resident while they waited for the above mentioned mobility aid to arrive in the home.

In an interview, staff #111 stated that the expectation was for registered staff to ensure the resident's plan of care was updated at all times, and confirmed that resident #001's plan of care was not reviewed and revised by the registered staff.

PLEASE NOTE: This evidence of non-compliance for resident #001 was found during inspection #2017_632502_0013.

The severity of this incident is actual harm/risk. The scope is identified as a pattern. The home failed to protect resident's #032, #038, #031, and #001 from harm related to the plan of care not being reviewed and revised when the care needs changed or care set out in the plan care was no longer necessary
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC) under s. 6. (10) (b) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6 Plan of Care, a compliance order is warranted. [s. 6. (10) (b)]

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

A CIR that was submitted to the MOHLTC revealed resident #017 experienced an

incident causing an injury and a subsequent transfer to hospital.

Record review of an assessment completed for resident #017 revealed he/she to be independent, consistent and reasonable, when making decisions. A review of an alternate assessment revealed that the resident required the use of a specific transfer equipment for transferring from bed to chair; and the use of a specific transfer aid for continence care. Further review of the CIR revealed that on a specified date in April 2017, staff #108 and #206 were in the process of transferring resident #017 from a toileting aid using a transfer aid as documented in the resident’s care plan; however the resident started to slide from the transfer aid and experienced an incident, causing injury.

In an interview, staff #111 stated that the transfer aid was ordered to be removed from this resident's use as was not effective. However, a review of resident #017's care plan revealed that this transfer aid was still included as a means of transferring resident #017.

In an interview, staff #111 confirmed that resident #017's plan of care was not revised when the care needs were changed when the plan was not effective. The use of the transfer aid was not removed from the plan of care although it was immediately removed from use for this resident following the above mentioned incident.

PLEASE NOTE: This evidence of non-compliance related to resident #017 was found during inspection #2017_324535_0014.: [s. 6. (10) (c)]

Additional Required Actions:

CO # - 001, 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 following are in place:
-there is a written plan of care for each resident that sets out the planned care for the resident,
-to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other,
-to ensure that the resident, the resident's substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and
-to ensure the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the use of a restrictive device of a resident is included in the resident's plan of care.

A CIR was submitted to the MOHLTC after an incident that resulted in an injury involving resident #031. The CIR further revealed resident #031 is dependent on a mobility aid, requires one staff assistance with transfers, and demonstrated responsive behaviours daily.

Review of a specific restrictive device assessment had been completed as alternative interventions in place had not been successful in preventing incidents.

Observations by the inspector revealed resident #031 had a restrictive device in place that had not been identified in the above mentioned assessment.

In an interview, staff #101 stated that the assessed restrictive device had not been delivered so in consultation with staff #122, it was decided to obtain an alternate order from the physician for the use of a different restrictive device in the meantime.

Review of the home's policy titles: Restraint Implementation Protocols, policy number VII-E-10.00, last revised November 2015, revealed under the procedure section; registered nurse/registered practical nurse is to update the resident's plan of care.

Review of resident #031's most recent written plan of care revealed a revision had been completed indicating the use of a restrictive device to prevent incidents.

In an interview, staff #101 stated the care plan had not been reviewed and revised to indicate the use of an alternate restrictive device.

In interviews, staff #122 and staff #111 acknowledged the use of the restrictive device had not been included in the resident #031's plan of care.
[s. 31. (1)]

2. The licensee has failed to ensure that the restraining of a resident by a physical device can be included in the plan of care when the resident has consented to it or, if the resident is incapable, a substitute decision-maker of the resident with authority has given that consent.

A CIR was submitted to the MOHLTC after an incident that resulted in an injury involving

resident #031. The CIR further revealed resident #031 is dependent on a mobility aid, requires one staff assistance with transfers, and demonstrated responsive behaviours daily.

Review of a specific restrictive device assessment had been completed as alternative interventions in place had not been successful in preventing incidents.

In an interview, staff #101 stated that the assessed restrictive device had not been delivered so in consultation with staff #122, it was decided to obtain an alternate order from the physician for the use of a different restrictive device in the meantime.

Review of the home's policy titled: Restraint Implementation Protocols, policy number VII-E-10.00, last revised November 2015, revealed under the procedure section; registered nurse/registered practical nurse is to obtain a written consent for the initial restraint use, annually thereafter, and upon any change in the restraint order.

Review of the physician's order tab revealed an initial order for the use of a restrictive device. Further review of the physician's orders revealed the initial order had been changed on an identified date in September 2017.

Review of an assessment completed for resident #031 at the time of the above mentioned incident revealed memory impairment with decision making severely impaired - never/rarely made decisions.

Review of the restrictive device assessment completed on an identified date in August 2017, revealed resident #031's substitute decision maker (SDM) had provided verbal consent, however the SDM had not provided consent for of the alternate restrictive device implemented on an identified date in September 2017.

In an interview, staff #101 stated he/she had not obtained consent from resident #031's SDM for the use of the alternate restrictive device that had been implemented on an identified date in September 2017. Staff #101 further stated he/she had not endorsed to the oncoming shift to follow-up with the SDM to obtain a consent either.

In interviews, staff #122 and staff#111 acknowledged that the home had failed to obtain consent from resident #031's SDM for the use of a restrictive device. [s. 31. (2) 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 the restraining of a resident is included in the resident's plan of care, and to ensure that the restraining of a resident by a physical device can be included in the plan of care when the resident has consented to it or, if the resident is incapable, a substitute decision-maker of the resident with authority has given that consent, to be implemented voluntarily.

WN #3: 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 are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result if a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIR was submitted to the MOHLTC related to a responsive behaviour incident that between residents #035 and #036. The CIR revealed that while resident #036 was wheeling him/herself by resident #035 he/she placed his/her hand on resident #035's table which upset the resident and resulting in resident #035 demonstrating a responsive behaviour towards resident #036, resulting in an injury. At the time of this incident there

was one to one (1:1) staff supervision in place to decrease the incidence of altercations between residents and harm towards other residents.

Review of resident #035's health record revealed he/she had been admitted to the LTCH with multiple underlying health conditions. Further review of the most recent written plan of care included unpredictable responsive behaviours with resident #035's triggers identified.

Review of an assessment completed for resident #035 revealed he/she had memory impairment and daily decision making is impaired with poor decision, cues or supervision required.

Observations of residents #035 and #036 during this inspection did not reveal any incidents of responsive behaviours between them.

In an interview, staff #141 stated she was the 1:1 staff for resident #035 on the above mentioned date. While in dining room, staff #141 stated she was standing to the left of resident #035's table when resident #036 came from behind in his/her mobility aid which upset resident #035 resulting in him/her suddenly getting up and demonstrating responsive behaviours towards resident #036 causing injury. Staff #141 stated the incident happened so quickly and that he/she did attempt to separate the two residents while calling for assistance.

In an interview, staff #142 stated he/she heard noises coming from the dining room and upon entering he/she observed resident #035 demonstrating a responsive behaviour towards resident #036 resulting in an injury. Staff #142 further stated he/she separated the two residents as did not see staff #141 nearby. Staff #142 also stated that staff #141 revealed he/she had left resident #035 unattended to get a piece of cutlery that resident #035 had requested.

In a follow-up interview, staff #141 continued to state he/she had been standing right at the dining table when the incident occurred and denied having left resident #035 unattended.

In an interview, staff #168 stated the home's investigation conducted after the incident, revealed that staff #141 had left resident #035 unattended even though being aware of his/her responsive behaviours. Staff #168 acknowledged that as a result of staff #141's actions the interventions developed and implemented to minimize the risk of altercations

and potentially harmful interactions between residents had failed. [s. 55. (a)]

2. A CIR was submitted to the MOHLTC related to an alleged incident of resident to resident abuse.

Review of the CIR revealed that at 0600 hours (HR) staff #162 heard raised voices coming from resident #004's room. When staff #162 went to assess, he/she observed resident #005 demonstrating a responsive behaviour resident #004. Further review of the CIS revealed that at 0658 HR, resident #004 reported to staff #163 that at 0600 HR resident #005 had ambulated in the room towards his/her bed. Resident #004 further reported that resident #005 had demonstrated several responsive behaviour towards him/her.

Review of an assessment completed for resident #005 at the time of the above mentioned incident revealed that he/she had memory impairment, with poor decision related to daily decision making, and required cues or supervision required, as result, resident #005's interview was not completed.

Review of resident #005's the written plan of care in place at the time of the incident revealed specific responsive behaviours that he/she had demonstrated. Further review of the written plan of care identified the triggers that contributed to the demonstration of responsive behaviours by resident #005 and the interventions in place to manage them.

Observations by the inspector did not reveal any incidents of altercations between residents #004 and #005 during this inspection.

In an interview, staff #162 stated that he/she had attended to resident #004 when he/she heard raised voices and that the resident reported the above mentioned incident to him/her. Staff #162 stated he/she had reported to staff #163 at the beginning of the shift that resident #005 was demonstrating responsive behaviours.

Staff #163 stated that the 1:1 staff was not assigned to resident #005 on the night of the above incident, as resident #005 had stopped demonstrating identified responsive behaviours at night. Staff #163 further stated that if he/she had been informed by the PSW that resident #005 was demonstrating responsive behaviours during the shift and before the incident, he/she would had administered resident #005's as needed (PRN) medication.

Review of resident #005's electronic medication administration record (e-MAR) revealed that the physician had ordered an identified medication to be given as needed when demonstrating responsive behaviours.

In an interview, staff #111 acknowledged that, as a result of RPN #163's lack of action, the interventions developed and implemented to minimize the risk of altercations and potentially harmful interactions between residents had failed. [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 if 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 #4: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a report to the Director is required, the

correct date and time of the incident are included.

A CIR was submitted to the MOHLTC on an identified date in August 2017, for an incident that occurred on an identified date in July 2017. The CIR further revealed under the description leading up to the incident, that resident #034 was transferred to hospital on an identified date in July 2017, related to a change in his/her physical health status.

Review of resident #034s progress notes revealed on an identified date in July 2017, staff #121 was waiting at the elevators when he/she heard a noise coming from a resident's room nearby. Staff #121 entered resident #034s room and observed a change in his/her health status and called for the evening registered nurse to assess.

In an interview, staff #118 stated staff #121 had called him/her to resident #043s room. Staff #118 further stated he/she assessed resident #034 and also called on the nurse for the oncoming shift, staff #130, to continue with the monitoring and assessment of resident #034 as it was the end of his/her shift.

In an interview, staff #130 stated that after consultation with the NM, resident #034 was transferred to hospital on an identified date in July 2017.

In an interview, staff #150 acknowledged the date and time of above mentioned incident were not documented accurately in the CIR when submitted to the Director. [s. 107. (4) 1.]

2. The licensee failed to ensure that actions taken in response to the incident included the outcome or current status of the individual or individuals who were involved in the incident.

A CIR was submitted to the Ministry of Health and Long Term Care (MOHLTC) which revealed resident #032 had an incident which resulted in a transfer to an alternate health institution due to an injury.

The CIR also revealed the Director had requested an amendment on an identified date in July 2017, to include the following:
-date of resident #032s return from hospital,
-the status of resident #032 upon return from hospital, and
-any prevention and management strategies in place prior to this incident.

A review of the Long Term Care Home (LTCH) portal at the time of this inspection revealed the above mentioned CIR report had not been amended with the above required information.

In an interview, staff #150 acknowledged that the CIR had not been amended to include the outcome or current status of resident #032. [s. 107. (4) 3.]

3. A CIR was submitted to MOHLTC which revealed that resident #034 was transferred to hospital on an identified date in July 2017, related to a change in his/her health status. The CIR also revealed that resident #034 was admitted with an underlying health condition. The CIR further revealed that resident #034's substitute decision maker (SDM) called the home on an identified date in August 2017, to inform staff #150 that resident #034 had also been diagnosed with another health condition. Staff #150 had documented in resident #034's progress notes that the home would conduct an internal investigation and follow-up with staff and the hospital related to the SDM's concerns. Upon re-admission to the home, resident #034's health status had changed significantly.

In an interview, staff #102 stated resident #034's SDM had requested for resident to be mobilized and therefore 40 days after resident #034 had been readmitted to the home, he/she was assessed to require an assistive aid with two staff present for all transfers.

The inspector requested a copy of the home's internal investigation notes and was provided with a package that included a copy of the CIR and hospital transfer notes. This package did not include any staff interviews or DOC actions taken.

In interviews, staff #121, #120 and #130 stated that staff #150 had not conducted any interviews with them regarding the above mentioned incident.

A review of the LTCH 's portal at the time of this inspection revealed the above mentioned CIR had not been amended with the outcome and status of resident #034.

In an interview, staff #150 acknowledged that the home had not amended the CIR to include the outcome of the internal investigation and the status of resident #034 upon re-admission to the home. [s. 107. (4) 3.]

4. A complaint was submitted to the MOHLTC, related to resident #003's injury of unknown cause. Review of the complaint revealed that resident #003's substitute decision maker (SDM) had visited and found resident #003 unable to mobilize

him/herself. The SDM reported the concern to nursing staff and a physician's order was received for further assessment. The next day the assessment revealed resident #003 had sustained an injury of unknown cause.

A CIR submitted to the MOHLTC revealed resident #003 had sustained an injury of unknown caused a significant change in his/her condition.

Further review of the CIR revealed that the home would update the CIR pending the outcome of investigation.

Review of the Ministry of Health and Long Term Care Critical Incident System portal (MOHLTC-CIR) revealed that the CIR had not been amended with resident #003's status.

In an interview, staff #150 stated that the CIR had not been amended with the subsequent hip surgery of resident #003.

PLEASE NOTE: This evidence of non-compliance for resident #003 was found during inspection #2017_632502_0013. [s. 107. (4) 3.]

5. The licensee has failed to ensure that when a report is submitted to the Director that it includes an analysis and follow-up action, including long term actions planned to prevent recurrence.

A CIR was submitted to MOHLTC which revealed that resident #034 was transferred to an alternate health institution on an identified date in July 2017, related to a change in his/her health status. The CIR also revealed that resident #034 was admitted with an underlying health condition. The CIR further revealed that resident #034's substitute decision maker (SDM) called the home on an identified date in August 2017, to inform staff #150 that resident #034 had also been diagnosed with another health condition. Staff #150 documented that the outcome of the investigation would be used to develop a plan to prevent recurrence.

The inspector requested a copy of the home's internal investigation notes and was provided with a package that included a copy of the CIR and hospital transfer notes. This package did not include any staff interviews or DOC actions taken.

In interviews, staff #121, #120, and staff #130 stated that the DOC had not conducted

any interviews with them regarding the above mentioned incident.

In an interview, staff #150 stated he/she had been absent from the home since an identified date in August 2017, to the time of this inspection and had not been able to commence the internal investigation. Staff #150 further stated he/she had not delegated the investigation of this incident to anyone in the home in his/her absence. Staff #150 acknowledged the home had not completed an internal investigation and therefore had not developed a plan for resident #034 to prevent recurrence of the above mentioned incident. [s. 107. (4) 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 when a report to the Director is required, the correct date and time of the incident are included,to ensure that actions taken in response to the incident included the outcome or current status of the individual or individuals who were involved in the incident, and to ensure that when a report is submitted to the Director that it includes an analysis and follow-up action, including long term actions planned to prevent recurrence, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #031 is being monitored at least every hour while restrained by a device.

A CIR submitted to the MOHLTC revealed an incident had occurred involving resident #031 which had resulted in an injury. The CIR further revealed resident #031 is dependent on a mobility aid, requires one staff assistance with transfers, and demonstrated responsive behaviours daily.

Review of an assessment completed for a specific restrictive device had been completed on an identified date in August 2017, as alternative interventions in place had not been successful.

Observations by the inspector revealed resident #031 had an alternate restrictive device in place other that what he/she had been assessed for.

In an interview, staff #101 stated that the restrictive device that resident #031 had been assessed for had not been delivered so in consultation with staff #122, it was decided to obtain an order for the use of an alternate restrictive device in the meantime. The physician's order the alternate restrictive device had been obtained on an identified date in September 2017.

Review of resident #031's health record failed to reveal that the use of the restrictive device had been monitored when initiated on an identified date in September 2017. Further review of resident #031's health record revealed a monitoring record was initiated by staff #101 after being interviewed by the inspector, therefore for a period of eight days the use of the restrictive device had not been monitored for safety and effectiveness.

In an interview, staff #101 stated that a monitoring record for resident #031 had not been initiated when the restrictive device had been applied and therefore neither the registered staff nor PSWs had been monitoring resident #031 hourly for safety or effectiveness of the restrictive devic.

In interviews, staff #122 and staff #111 acknowledged registered staff and PSWs had failed to monitor resident #031 hourly for safety and effectiveness. [s. 110. (2) 3.]

2. The licensee had failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented including all assessment, reassessment and monitoring, including the resident's response.

A CIR submitted to the MOHLTC revealed resident #031 sustained an injury after an incident. The CIR further revealed resident #031 is dependent on a mobility ad, requires one staff assistance with transfers, and demonstrates responsive behaviours daily.

Observations by the inspector revealed resident #031 had a restrictive device in place.

Review of the home's policy titles: Restraint Implementation Protocols, policy number VII-E-10.00, last revised November 2015, revealed under the procedure section; registered nurse/registered practical nurse is to review and document every eight hours on the restraint monitoring record to evaluate the need for continues restraint use, effectiveness of restraint, and that it continues to be required.

In an interview, staff #101 stated that he/she had not initiated a restrictive device monitoring record and as a result resident #031 response to the use of a restrictive device had not been assessed or monitored.

In interviews, staff #121 and staff #111 acknowledged that resident #031's response to the use of a restrictive device had not been assessed or monitored as per legislative requirements. [s. 110. (7) 6.]

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 resident #031 is being monitored at least every hour while restrained by a seatbelt device, and to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Director of Nursing, and Personal Care works regularly in that position on site at the home for the following amount of time per

week: in a home with licensed bed capacity of 65 beds or more, at least 35 hours per week.

This inspection protocol was inspector initiated during a critical incident, complaint and follow-up (CCF) inspection in the home. Upon entering the home the inspectors were greeted by staff #149 and staff #145 who had just started the same day. Staff #149 further stated to the inspectors that the Director of Care was absent from the home.

Midland Gardens Care Community has a licensed bed capacity of 299 beds, and therefore the Director of Nursing and Personal Care is required to work at least 35 hours per week.

Review of staff #150's attendance in the home from identified dates in August 2017, to September 2017, revealed the following:
-absent August 8-11, 2107, four days, 30 hours (HR),
-absent August 14-18, 2017, five days, 37.5 HR,
-present in the home August 21 and 22, 2017,
-absent August 23, 24, 2017, two days.15 HR,
-vacation August 25 to September 4, 2017,
-absent September 5-8, 2017, 4 days, 30 HR,
-absent September 11-15, 2017, five days, 37.5 HR,
-absent September 18-22, 2017, five days, 37. 5 HR, and
-absent September 25-29, 2017, five days, 37.5 HR.

Review of the above noted DOC attendance record revealed there were five weeks where the home's Director of Nursing, and Personal Care did not work regularly in that position on site at the home for the following amount of time per week:
- in a home with licensed bed capacity of 65 beds or more, at least 35 hours per week.

In an interview, staff #150 stated he/she had been away from his/her DOC duties since an identified date in August 2017, except for two days in August 2017. Staff #150 further stated he/she had disclosed the reason for the absence to staff #149 on an identified date in August 2017. Staff #150 also stated that he/she had an appointment to reassess his/her status.

In an interview conducted on an identified date in September 2017, staff #111 stated that he/she had not been the interim DOC during the absence of staff #150 during the month of August. Staff #111 further stated he/she had been asked by staff #145 on either of two

identified dates in September 2017, to be the interim DOC and that he/she accepted verbally two to three days later. Staff #111 could not provide exact dates. A letter was provided to staff #111 dated three days after accepting verbally, indicating he/she had been given the role of interim DOC. Staff #111 further stated he/she had not been asked prior to the above mentioned dates to be the interim DOC and that staff in the home had just assumed he/she had taken the role.

In interviews, staff #173, #160, #153 and #131 stated that they had assumed staff #111 was the interim DOC as he/she had taken the role previously when there had not been a DOC in the home

In an interview, staff #149 stated that he/she had been in regular contact with staff #150 during his/her absence and had not expected the absence to be this long. Staff #149 acknowledged that now in hindsight there should have been a more formalized plan to address the absence of the DOC to meet legislative requirements. [s. 213. (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 the home's Director of Nursing, and Personal Care works regularly in that position on site at the home for the following amount of time per week: in a home with licensed bed capacity of 65 beds or more, at least 35 hours per week, to be implemented voluntarily.

Issued on this 1st day of November, 2017

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) :	JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), VERON ASH (535)
Inspection No. / No de l'inspection :	2017_630589_0015
Log No. / No de registre :	007919-17, 008314-17, 008469-17, 013957-17, 014235-17, 014343-17, 015486-17, 016911-17, 019369-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 20, 2017
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 MIDLAND AVENUE, SCARBOROUGH, ON, M1N-4B2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kris Coventry

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

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 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

1) The plan must include a process to ensure collaboration occurs among disciplines.
2) The home shall also include scheduled meetings which will allow direct care staff opportunities to collaborate in the development and implementation of the plan of care.
3) Continue to schedule and conduct management and direct care staff meetings that allow for such collaboration with each other in the development and implementation of the plan of care

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each part of the plan.

Please submit the plan to: joanne.zahur@ontario.ca by October 27, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the developments and implementation of the plan so that the different aspects of care are integrated and are consistent with and complement each other.

A CIR was submitted to the MOHLTC, for an incident involving resident #033. The CIR revealed that resident #033 had been provided morning care and settled back into bed by staff #154. When staff #154 left the room to assist another resident he/she heard a noise. Upon investigating staff #154 found resident #033 had experienced a fall in another resident's room. Resident #033 was transferred to hospital for an assessment of an injury sustained in the above mentioned incident.

Review of the most recent written plan of care revealed staff #107 had revised the interventions to include time identified safety checks to be completed. The CIR also revealed the same above mentioned intervention under the immediate actions section of the report.

Review of the point of care electronic documentation system (POC) from an identified period of time to the current inspection time frame revealed that identified safety checks had not been documented.

In an interview, staff #154 stated that the POC had not indicated the above mentioned and therefore he/she had not documented that this had been completed. Staff #154 further stated that only in the last week and a half had this intervention been added to the POC.

In an interview, staff #107 stated that he/she had not audited for the completion of this intervention as he/she expected the staff to have completed them as indicated in the care plan. Staff #107 was not able to provide documentation from the POC; only providing that alternate reports had been completed

Staff #107 acknowledged that staff had not collaborated with each other in the implementation of the plan of care for resident #033. (589)

2. A CIR was submitted to the MOHLTC, which revealed that resident#034 was transferred to hospital on a specified date related to a change in his/her physical health status.

Review of the health institution's transfer notes which included two revealed two new health conditions.

Review of resident #034's health record in PCC under the medical diagnosis tab did not reveal the above two health conditions had been added after his/her re-admission to the home.

In an interview, staff #148 stated he/she had not seen the two transfer notes and therefore was not aware of the new health conditions. Staff #148 further stated he/she would send a referral to the registered dietician (RD) related to one of the new health conditions.

In an interview, staff #150 stated the home had not received discharge notes for resident #034 upon his/her re-admission to the long term care home (LTCH) on and that he/she had to request them from the health institution. Upon receiving the discharge notes for resident #034, staff #150 stated he/she had them in his/her possession and could not recall if he/she had given a copy to resident #034's home areas registered staff and physician. As a result, staff #150 acknowledged that staff and others involved in the different aspects of care had not collaborated with each other in the developments and implementation of the plan. (589)

3. A CIR was submitted to the MOHLTC related to an incident that occurred between two residents. The CIR revealed that resident #038 had demonstrated a responsive behaviour towards resident which resulted in an injury to resident #038. The CIR further revealed a referral had been completed related to resident #037's demonstration of responsive behaviours and that the referral was pending.

Review of an assessment completed for resident #037 revealed memory impairment and impaired memory recall and orientation with poor decision making and cues or supervision required. Review of the written plan if care at the time of the above mentioned incident revealed identified responsive behaviours demonstrated by resident #037. Further review revealed a referral had been completed to the home's internal behavioural team.

Review of resident #037's documentation notes revealed that staff #168 had completed a follow-up response to the referral. The follow-up response included an assessment of medication, most recent RAI-MDS scores and a plan to trial

resident #037 on another floor.

In an interview, staff #168 stated the social worker in the home had shown resident #037 an alternate room on another floor and that he/she had refused to move. Staff #168 further stated that he/she thought that staff #107 had been aware however could not confirm definitively that staff #107 had been informed of trialing resident #037 on another floor.

In an interview, staff #107 who is in charge of an identified floor where resident #037 resides acknowledged that he/she was not aware of any trial to move resident #037 to another floor. (589)

4. A CIR was submitted to the MOHLTC, for an incident involving resident #033. The CIR revealed that resident #033 had been provided morning care and settled back into bed by staff #154. When staff #154 left the room to assist another resident he/she heard a noise. Upon investigating staff #154 found resident #033 had experienced an incident in another resident's room. Resident #033 was transferred to hospital for an assessment of an injury sustained in the above mentioned incident.

Review of the transfer notes revealed the physician had recommended a specific consultation as an outpatient and had included a completed referral note. Review of resident #033's health record revealed under the physician's order tab that an order had been written by resident #033's primary physician for this consultation.

Review of resident #033's electronic documentation notes revealed that a consultation appointment had been booked, but was cancelled by a family member. The documentation notes further revealed that the family member was to call the LTCH back with the date of the re-booked appointment. At the time of this inspection, the appointment had not been rebooked.

In an interview, staff #155 stated that he/she should have documented in the 24 hour report for staff to follow-up with resident #033's family and also should have reported to the fourth floor manager that family had cancelled resident #033's the appointment and had not called the LTCH back with a new date and time for the appointment.

In an interview, staff #107 acknowledged that staff had failed to follow-up

regarding the re-booking of the appointment with family and therefore had not collaborated with each other in the developments and implementation of the plan.

The severity of this incident is actual harm/risk sustained by residents. The scope is identified as a pattern.
The home failed to collaborate with each other in the provision of care related to a neurology appointment and in the provision of nightly hourly safety checks for resident #033. The home also failed to collaborate with each other in the development and implementation of the plan for resident #034 and failed to protect resident #038 from harm as a result of a resident to resident altercation with resident #037.
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC) under s. 6. (4) (b) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6., Plan of Care, a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 17, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care is provided to the resident as specified in the plan of care for resident's #002 and #034.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each part of the plan.

Please submit the plan to: joanne.zahur@ontario.ca by October 27, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care is provided to resident #034 as specified in the plan.

A complaint was submitted to the MOHLTC related to improper care provided to resident #002. Review of the complaint revealed that the home failed to properly document resident #002's known underlying health conditions in resident #002's plan of care.

In an interview, resident #002 stated that a nursing staff inserted an improper continence device that resulted in altered skin integrity to an identified area of resident #002's body. Resident #002 stated that staff #124 assisted him/her in removing the above mentioned device few hours later.

Review of the written plan of care revealed that resident #003 required the use of a continence device related to an underlying health condition. Further review of resident #002's written plan of care revealed that he/she has identified

underlying health conditions that require specific interventions related to the use of continence devices.

On an identified date in September 2017, in a medication room, the inspector observation a box containing continence devices with a disclaimer written on the box, noting a possible reaction if used. Staff #133, who was present during the observation stated that the above mentioned box contained the only available continence devices available in the medication room and that one was used earlier on the same day on resident #002.

In an interview, staff #124 confirmed he/she had removed an identified continence device from resident #002, and believed that may not have been the required continence device for resident #002, however could not confirm this. Staff #124 did confirm that resident #002 had altered skin integrity to an identified body area.

In an interview, staff #100 confirmed that the above identified continence devices had been used previously up to an identified date in September 2017, when resident #002 developed altered skin integrity. He/she stated that since resident #002 had a reaction, alternate continence devices were purchased.

In an interview, staff #111 stated that he/she had ordered the alternate continence devices and was not aware that the supplier had delivered the required continence device until resident #002 developed a reaction. Staff #111 further stated that after resident #002 experienced a reaction, he/she re-ordered the required continence devices, and that resident #002's name had been written on the box to avoid any future mistakes.

PLEASE NOTE: This evidence of non-compliance for resident #002 was found during inspection #2017_632502_0014. (589)

2. A CIR was submitted to the MOHLTC which revealed that resident #034 was transferred to hospital related to a change in his/her health status. The CIR also revealed that resident #034 had been admitted with identified health condition. The CIR further revealed that resident #034s substitute decision maker (SDM) called the home on an identified date in August 2017, to inform staff #150 that resident #034 had also been diagnosed with an injury.

Review of resident #034s written plan of care at the time of the incident revealed

he/she was at risk for incidents related to periods of changes in his/her health status and cognitive impairment. Further review of the written plan of care revealed that resident specific interventions were to be in place.

Resident #034's written plan of care completed on an identified date in August 2017, which was completed after the above mentioned incident revealed the same interventions as identified above.

Observations by the inspector revealed resident #034 had all of the specified interventions in place except for one. Review of the point of care (POC) flow sheets revealed that staff #114 had documented that this identified intervention had not been applied on an identified date in September 2017.

In an interview, staff #114 stated that when he/she had worked on an identified date in September 2017, this intervention was not in place and that he/she had not reported this to the registered staff at the time because he/she thought resident #034 did not require it any more. PSW #114 also stated that on the next two days this intervention had also not been in place.

Further observations by the inspector revealed the identified intervention had been re-applied to resident #034's bed, three days later.

In an interview, staff #117 stated that after staff #114 had been interviewed by the inspector he/she had reported that resident #034 required an identified intervention to be in place, which staff #117 then applied.

In an interview, staff #111 acknowledged that resident #034 did not have the identified intervention in place for three days and therefore the care set out in the plan of care was not provided to resident #034 as specified in the plan. [s. 6. (7)]

The severity of this incident is actual harm/risk as one resident sustained altered skin integrity and the other resident sustained an injury of unknown cause. The scope is identified as a pattern.
The home failed to protect resident #002 from harm related to an identified health condition response and failed to protect resident #034 from a potential for harm related to not providing care to as specified in the plan.
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC)

under s. 6. (7) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6 Plan of Care, a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that when a resident has been re-assessed due to changes in their care needs or the care provided is no longer necessary, that the plan of care is reviewed and revised:
1. Develop a process on how the home plans to communicate to their staff the following:
-resident #032 no longer required assistance by one staff for ambulation related to safety,
-resident #031 had a seatbelt restraint in place while waiting for a table top restraint to be delivered,
-resident #037 was assessed by the home's internal behavioural team with new interventions to be implemented that were not updated to the plan of care, and
-resident #001 was now bedfast and no longer used a wheelchair as their primary mode of locomotion with the ability to self-propel.
2. Review and update any relevant policies and procedures related to when residents are assessed ensuring the plan of care is reviewed and revised.
3. Develop a process on how resident plan of care revisions are communicated to staff.
4. Provide staff training so they can understand their role and responsibilities when there are changes in the residents' status.
5. Develop an auditing tool to monitor that when residents are assessed, that the plan of care are reviewed and revised.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance, for each part of the plan.
Please submit the plan to: joanne.zahur@ontario.ca by October 27, 2017.

Grounds / Motifs :

1. While conducting an inspection in the home, resident #001 made a direct complaint of inappropriate care to the inspector related to a specific incident.

Record review revealed that resident #001 had an assessment completed that revealed he/she was independent and a reasonable decision-maker. The assessment also assessed the resident with altered mobility all or most of the time, with no mode of transportation listed. However, a review of resident #001's plan of care revealed that the resident used a mobility aid independently as their primary mode of locomotion.

The inspector observed that resident #001 was unable to independently mobilize

him/herself since readmission from an alternate health institution in August 2017.

During an interview, staff #102 confirmed that resident #001 was currently inactive and waiting on a specialized mobility aid. He/she also stated that there was no current plan in place to mobilize the resident while they waited for the above mentioned mobility aid to arrive in the home.

In an interview, staff #111 stated that the expectation was for registered staff to ensure the resident's plan of care was updated at all times, and confirmed that resident #001's plan of care was not reviewed and revised by the registered staff.

PLEASE NOTE: This evidence of non-compliance for resident #001 was found during inspection #2017_632502_0013. (589)

2. A CIR was submitted to the MOHLTC related to resident #031 after an incident that had occurred on an identified date in June 2017. The CIR further revealed resident #031 was dependent for mobility, requires one staff assistance with transfers, and often demonstrates responsive behaviours.

Review of resident #031's health record revealed an assessment had been completed on an identified date in August 2017, for the use of a restrictive device when up in the mobility aid. The assessment revealed that alternatives had been in place for over a year and had not been effective.

Observations by the inspector revealed resident #031 had a restrictive device in place that was not the restrictive device that had been identified in the assessment completed.

Review of resident #031's health record failed to reveal that resident #031 had been reassessed for the use of an alternate restrictive device prior to this device being applied.

In an interview, staff #101 stated that the assessed restrictive device had not been delivered so in consultation with staff #122, it was decided to obtain a physician's order for an alternate restrictive device until the assessed restrictive device was available to be applied. Staff #101 further stated that he/she had not completed a reassessment as he/she thought the original assessment that had

been completed was sufficient. Staff #101 also stated he/she was aware that the two devices are different and that he/she should have completed a reassessment.

In interview, staff #121 and staff #111 acknowledged that a reassessment for the use of the alternate restrictive device for resident #031 had not been completed prior to application of this device and that the plan of care had not been reviewed and revised when resident #031's care needs changed. (589)

3. A CIR was submitted to the MOHLTC for an incident that occurred between two residents. The CIR revealed that resident #038 had wandered into resident #037's room and that resident #037 demonstrated a responsive behaviour towards resident #038 which resulted in an injury. The CIR further revealed a referral had been completed related to his/her demonstration of responsive behaviours and that the referral was pending.

Review of health record for resident #038 revealed he/she was admitted with identified underlying health conditions, the ability to mobilize without the aid of a mobility aid, and the demonstration of identified responsive behaviours. Further review of resident #038's health record revealed resident specific interventions to be implemented when demonstrating responsive behaviours.

Review of an assessment completed for resident #038 revealed memory impairment that affected memory recall and orientation with poor decision making and cues or supervision required.

Review of health record for resident #037 revealed he/she was admitted with identified underlying health conditions, that he/she ambulated independently without the aid of any assistive aid and demonstrated specific responsive behaviour related to his/her belongings and personal space.

Review of an assessment completed for resident #037 revealed memory impairment which affected memory recall and orientation with poor decision making and cues or supervision required.

Observations by the inspector revealed resident #037 was demonstrating responsive behaviours in the main area by the nursing station towards another resident however, a PSW intervened and was able to calm resident #037 down. Further observations conducted on three identified dates revealed resident #037

was not demonstrating any responsive behaviours.

Review of the written plan of care in place at the time of the above mentioned incident revealed specific interventions to be implemented when responsive behaviours were demonstrated.

Observations conducted during this inspection by the inspector revealed resident #037 participating in scheduled activity programs.

Review of resident #037's documentation notes revealed the resident was assessed on behaviour rounds with new interventions to be implemented.

In an interview, staff #122 acknowledged that resident #037 had been assessed as the care set out in the plan of care had not been effective and that the plan of care had not been reviewed and revised to include the newly discussed action plan. (589)

4. The licensee has failed to ensure when the resident was reassessed that the plan of care was reviewed and revised when the care needs changed or care set out in the plan care was no longer necessary.

The licensee has failed to ensure when the resident was reassessed that the plan of care was reviewed and revised when the care needs changed or care set out in the plan care was no longer necessary.

A CIR was submitted which revealed resident #032 had an incident on the same day which resulted in a transfer to an alternate health institution for assessment. Further review of the CIR revealed that resident #032 had sustained an injury.

Review of the most recent written plan of care revealed that resident #032 used a mobility aid for ambulation and now required supervision for safety as a result of the above mentioned incident.

In an interview, staff #113 stated that resident #032 now required supervision by one staff member when ambulating to the dining room for meals and for continence care.

Observations by the inspector revealed resident #032 ambulating independently with his/her mobility aid from the main dining room to the elevators and then into

the elevators.

In an interview, resident #032 stated he/she basically does everything for him/herself, requiring very little assistance from staff.

In an interview, staff #171 stated he/she had completed a reassessment of resident #032 the prior week, however he/she could not identify the exact date. Staff #171 further stated the reassessment had deemed resident #032 capable related to mobility and therefore was to be discharged from the program.

Further review of the most recent written plan of care continued to reveal that resident #032 required supervision when ambulating with a mobility aid.

In a follow-up interview, staff #171 stated he/she had not reviewed and revised resident #032's plan of care at the time of the re-assessment and was planning to update the plan of care right after this interview with the inspector.

In an interview, staff #111 acknowledged the care set out in the plan was no longer necessary for resident #032 and that staff #171 was to have reviewed and revised the plan of care at the time of the reassessment and not a week later.

The severity of this incident is actual harm/risk. The scope is identified as a pattern.
The home failed to protect resident's #032, #038, #031, and #001 from harm related to the plan of care not being reviewed and revised when the care needs changed or care set out in the plan care was no longer necessary
The previous compliance history revealed in resident quality inspection (RQI) #2016_353589)_0016, a written notice with a voluntary plan of correction (VPC) under s. 6. (10) (b) had been issued. As a result of ongoing non-compliance with LTCHA 79/10, s.6 Plan of Care, a compliance order is warranted. (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

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