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_632502_0013	008060-17, 012087-17	Complaint

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

JULIENNE NGONLOGA (502), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 27, and 28, 2017.

The following complaints were inspected during this inspection: log #008060-17, related to injury with unknown cause, and #012087-17 related to improper care.

The following evidence related to s. 6. (5), s. 6. (10) (b), s. 5, and r. 107. (4) 3. v. will be captured under inspection report 2017_630589_0015.

The following evidence related to s.5 will be captured under inspection report 2017_324535_0014.

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:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

3 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' rights to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

While conducting an inspection in the home, resident #001 made a direct complaint to the inspector of improper care. Resident #001 told the inspector that on an identified date, he/she made a request to staff #175 to be transferred from bed to the wheelchair for a specified period of time. The resident further stated that he/she was transferred to the wheelchair and he/she enjoyed being up in the chair for a specified period of time. The resident further stated that after the above identified period of time he/she started to feel tired, and made several requests to be transferred back to bed, but was not transferred until a specified period of time. The direct care staff informed him/her they were not able to transfer him/her back to bed upon his/her request because other staff members were providing care and assistance to other residents, and there were not enough staff available on the unit to perform the transfer. became uncomfortable and would be reluctant to ask for assistance from staff in the future.

Review of the Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessment completed on an identified date, revealed that resident #001 was cognitively intake, consistent and a reasonable decision-maker.

Review of resident #001's most recent written plan of care revealed that resident #001 had a specified medical condition. Further review of the plan of care revealed that resident #001 was to be turned and repositioned at least every two hours, and more often as needed when in bed.

In an interview, staff #175 confirmed the occurrence of the above mentioned incident. The staff stated that he/she did not make an arrangement to transfer the resident back to bed after the period of time identified above. Staff #175 stated he/she was aware that resident #001 was upset, as wanted to be transferred back to bed; however, all staff were assisting other residents or on break, and he/she had to provide care for another resident.

In an interview, staff #182 confirmed that he/she was aware that resident needed to be transferred back to bed, as resident #001 was upset. Staff #182 stated that he/she told the resident that there were not enough staff on the unit, and that they would transferring him/her back to bed as soon as possible. Both staff denied that the resident complained of experiencing discomfort during the incident.

In an interview, staff #111 acknowledged that resident #001's was not treated with courtesy and respect, as nursing staff show a lack of acknowledgement and personal attention toward resident #001 for approximately identified number of hours. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's right was fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respect their dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that this plan was implemented.

Review of the complaint submitted to the Ministry of Health and Long-Term care (MOHLTC) revealed that on an identified date, a registered nursing staff noted that resident #001 had an identified area of altered skin integrity.

Review of RAI-MDS assessment completed on an identified date, revealed that resident #001 was cognitively intact, consistent and reasonable with daily decision making. Further review of the RAI-MDS revealed that resident #001 was incontinent of bowel and bladder, and required extensive assistance from one staff member.

Review of resident #001's written plan of care completed on an identified date, under the skin integrity focus revealed and that resident #001 had an identified impaired skin integrity, had a standing order for a treatment, and the area should be protected from excessive moisture. Further review of the written plan of care revealed that resident #001 required specified continence product and total assistance from one staff member due to specified medical conditions.

Review of an email sent to staff #150 by staff #165 on an identified date, revealed that resident #001 had required personal care assistance from staff due to his/her identified medical condition. Staff #165 also wrote that resident #001 had been seen by a TENA representative four months earlier, and recommended a specified system that was proven to be effective. Staff #165's email further revealed that the former executive director of the home requested that staff stopped the implementation of the system identified above as the home had other priorities. Staff #165 further wrote that resident #001 would benefit from the implementation of the system, as it would allow the individualized toileting plan to be implemented.

In an interview, resident #001 stated that he/she was required staff assistance, after each incontinence episode.

In interviews, staff #178, #179, and #181 stated the system identified above that was trialed few months earlier was not implemented, as result resident #001 did not have an individualized toileting plan.

In an interview, staff #165, stated that the resident #001's individualized toileting plan had not been implemented, because he/she was directed by the previous executive director to stop the implementation of the system identified above that was trialed in few months earlier, which was six month later at the time of this inspection. [s. 51. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that this plan is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date, a complaint was submitted to the MOHLTC related to improper skin care. Review of the complaint revealed that in a specified period of time, a registered nursing staff noted that resident #001 had an identified area of altered skin integrity.

Resident #001's identified treatment measure, was not available to administer, so the nursing staff ordered another treatment measure the same day. Further review of the complaint revealed that five days after being ordered, resident #001's treatment measure

identified above was not available and staff applied an identified available product instead.

In an interview, resident #001 stated that on an identified date, nursing staff had ordered his/her treatment measure after he/she had noted an area of altered skin integrity identified above. As the above identified treatment measure was not available, staff were applying an identified treatment measure available in the home. Resident #001 further stated that identified in home treatment measure was not working to relieve symptoms. Resident #001 also stated that five days later, the prescribed treatment measure was still not available, he/she then complained to his/her primary physician, who then assessed him/her and prescribed a specified medication.

Review of the multidisciplinary progress notes revealed that on an identified date, resident #002’s primary physician assessed the resident and documented an area of impaired skin integrity and a specified medical condition.

Interview with staff #152 stated that resident #001’s above mentioned treatment measure was delivered on an identified date.

Review of the fifth floor Medi System Pharmacy shipping report for a specified period of time, revealed that none of resident #001’s prescribed drugs was received in the home during the period of time identified above, as there were no signatures present on the document.

Review of the electronic treatment record (e-TAR) revealed that the identified treatment measure was signed as administered daily for an identified period of time. This contradicted resident #001's statement that an in home measure was being administered instead of his/her measure that had been prescribed as specified above. Furthermore, there was no evidence that resident #001’s treatment cream was received in the home.

Interviews with staff #100, #182, and, #183 revealed that they usually signed off as resident #001’s treatment measure specified above had been administered based on the PSWs report, even though they are not present, and they are unaware what type of product was being applied. The above registered nursing staff were not able to confirm if the prescribed treatment measure was available during the period of time identified above.

In an interview, staff #150 stated that resident #001 had a good relationship with his/her

primary care giver, and would have not complained to the physician and him/her about being without the treatment measure for five days if his/her treatment measure was being administered as prescribed. Staff #150 further stated that he/she was aware that resident #001 usually requests that staff administer any apply any product as it is better than having nothing administered to his/her identified area of impaired skin integrity.

In an interview, staff #111 acknowledged that resident #001's treatment measure, required for his/her health for an identified period of time, was not administered as prescribed [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 15th day of November, 2017

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

Original report signed by the inspector.