Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 27, 2017	2017_324535_0014	008040-17, 011346-17, 011347-17	Follow up

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

VERON ASH (535)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 2017.

The following critical incidents were inspected during this inspection: log # 007919-17 (related to transfer and lift), and log #0169111-17 (related to transfer and lift).

Findings of non-compliance related to LTCH Act, 2007, s. 5, identified in inspection report #2017_630589_0015, will be issued in this report; findings of non-compliance related to LTCH Act, 2007, s. 5, identified in inspection report #2017_632502_0013, will be issued in this report; and findings of non-compliance related to O. Reg. 79/10, r. 9. (1), identified in inspection report #2017_324535_0014, 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), Interim Director of Care (I-DOC), Associate Director of Care (ADOC), former Associate Director of Care (f-ADOC), Registered Nurses (RN), Registered Practical nurse (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Nursing Rehabilitation Coordinator (NRC), Director of Food Services (DFS), Food Service Supervisor, Nurse Managers (NM), 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 related residential areas, observations of staff to resident interactions, resident transfers 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 - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control
Pain
Personal Support Services
Safe and Secure Home

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

8 WN(s)
3 VPC(s)
4 CO(s)
2 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2017_644507_0003	535
O.Reg 79/10 s. 52. (2)	CO #001	2017_420643_0006	535
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #002	2015_324567_0016	535

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On an identified date while conducting follow up observations on an identified floor, the inspector observed the following incident:

The inspector observed resident #025 wandering to the North corridor of the fourth floor unit and exit seeking by pushing against the door. At that same time, housekeeping staff #200 was walking the staircase to an upper floor when he/she noticed contractor #184 exited the fourth floor unit door, with resident #025 standing immediately inside the unit and started pushing on the exit door. Contractor #184 left the area without waiting for the exit door magnetic lock to re-engage therefore not securing the unit before leaving the area.

During an interview, housekeeping staff #200 stated that he/she saw the resident standing inside the door and stopped at the door to ensure the resident did not get out the door and into the staircase. The staff stated that he/she tried to remind the contractor to ensure the magnetic lock was engaged at the door before going down the staircase; however, he/she did not wait to listen to the message. The housekeeping staff further stated that he/she would advise the supervisor of the incident.

During an interview, the Director of ES #110 stated that all contractors received education and training related to working with resident on the units; and that he/she would meet with contractor #184 and remind him/her of the importance of waiting until the magnet lock was engaged before leaving the exit door and going downstairs. The Director of ES confirmed that the incident could have potentially compromised the safety and security of resident #025 if he/she had gone outside the exit door and into the staircase. [s. 5.]

2. On an identified date, a critical incident was submitted to the MOHLTC related to an injury of resident #002. Review of the critical incident and progress notes revealed that on an identified date and time, a personal support worker (PSW) found resident #002 in his/her room with the injury.

In an interview, resident #002 stated that he/she told recreation staff which recreational activities that he/she was interested in doing.Recreation staff told him/her to follow the home’s activities calendar because it was based on Montessori teaching. Resident #002 stated that before he/she was injured on the date identified, he/she told recreation staff that he/she was had nothing to do in the home. Resident #002 further stated that he/she found sharp objects on the linen cart in the hallway which was available on each floor.

Review of MDS assessment revealed that resident #002 was consistent and reasonable with daily decision making abilities. A review of resident #002’s most recent written plan

of care revealed multiple related diagnosis; and interventions implemented directed staff to check the resident's room every shift; and to remove all sharp objects.

The inspector conducted observations on other units to observe for sharp objects and found the following:

- On an identified date, the inspector observed a sharp objects unsupervised on the linen cart in the hallway of the third floor South. PSW #182 told the inspector that he/she had left the sharp object in that location as he/she was going to shower a resident after lunch.
- On the same date, the inspector observed four sharp objects left unsupervised on the linen cart in the hallway of the third floor South. PSW #125 told the inspector that he/she had left the sharp object in that location.
- On another identified date, the inspector observed four sharp objects left unsupervised on the linen cart in the hallway on the fifth floor North.

During an interview, NM #128 stated that staff members have been trained to remove sharp objects and other unsafe objects from the linen cart as soon as they were finished using them. NM#128 acknowledged that leaving sharp objects unsupervised in the linen cart in the hallway had not ensured a safe environment for the residents.
PLEASE NOTE: This evidence of non-compliance related to resident #002 was found during inspection #2017_632502_0014. [s. 5.]

3. This inspection protocol was initiated by the inspector as resident #006 was observed walking unsupervised in the stairwell.

On an identified date, the inspector observed resident #006, who was unsupervised and unaccompanied, enter the code into the keypad of the door located on an identified floor and walk down the stairwell to the ground floor. This observation was brought to the attention of the Acting DOC #111 who then directed the ESM to immediately change the code to the door leading to that stairway.

On an identified date, the inspector observed resident #006, who was unsupervised and unaccompanied, enter the code into the keypad of the door and walked up the stairwell to his/her assigned floor. This observation was brought to the attention of NM #156 who stated that the code to this door had been changed two days ago and that resident #006 had been advised to use the elevator; the NM stated that furthermore, the resident may have gotten the access code from a family member during the recent visit.

In an interview, resident #006 stated that he/she prefers to use the stairwell because the elevators were sometimes busy. The resident further stated that staff members were aware of his/her use of the stairwell and were upset with him/her for doing so.

In interviews, PSW #161 and RPN #127 stated that resident #006 always takes the elevator unsupervised, however they were unsure if the resident was assessed by the physiotherapist prior to doing so. In an interview, PT #102 stated that he/she had observed resident #006 walking down the staircase on multiple occasions, but he/she had not assessed or cleared the resident to use the stairs.

In interviews, the Acting DOC #111 stated that prior to using the stairwell independently; resident #006 should have been assessed and cleared to do so by the PT #102. The home failed to demonstrate that they provided a safe and secure environment because resident #006 was provided the access codes and was able to walk up and down the stairs unsupervised. Further to this assessment, staff members should have considered the resident's level of understanding potential risk to self and others and ensure the doors were secured after exiting and entering.
PLEASE NOTE: This evidence of non-compliance related to resident #002 was found during inspection #2017_632502_0013.

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with a voluntary plan of compliance or compliance order. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date while conducting observations related to a follow up inspection, the inspector observed the following areas of concerns:

On an identified floor, shower room #2 was observed to have a removal of a piece of the ceiling tiles with size approximately 20 cm x 20 cm and the open area was covered with a piece of orange plastic sheet. During an interview, the maintenance worker # 176 who entered the shower for repair work informed the inspector that the leakage was a result of condensation from the pipes in the ceiling. On the opposite side of the partition wall the ceiling tile remained intact however the tile had orange water marks and a few small areas with black mold-like substance identified and this was confirmed by the maintenance worker during an observation.

On another identified floor, while observing a resident's room listed in the previous follow up inspection, resident #026 requested that the inspector observe the large hole in his/her washroom. The inspector observed a 15 cm x 15 cm hole in the dry wall in the corner below the lever of the toilet, with exposed pipes and dust debris observed in the open area. The resident voiced concerns related to not knowing what he/she was breathing from the opening in the wall. During an interview, the Direct of Environmental Services (ES) #110 confirmed that the area of disrepair was not entered into the automated work requisition system for repair.

On another identified floor, the inspector observed an identified resident's room, although the previous area identified in the report was repaired, a new area of disrepair was

identified related to the ceiling tile directly inside the washroom door appeared to be falling/bulging. During an interview, the Director of ES #110 informed the inspector that the reason for the bulging was because the ceiling tile did not fit the open area in the ceiling; and he/she confirmed that the ceiling tile should have been fixed, and that the bulging ceiling tile was not entered into the automated work requisition system for repair.

On an identified date, inspector #605 observed a large hole in the drywall to the lower portion of the washroom wall inside the entrance of room #515. During an interview, the Director of ES #110 confirmed that the dry wall disrepair was not entered into the automated work requisition system for repair; however, on another identified date, the maintenance worker completed the drywall repair.

On an identified floor, immediately outside shower room # 2 in the common hallways, the inspector observed a illuminated exit sign was hanging lower than normal. With closer observation, it was discovered that the ceiling tile which held the exit sign in place was broken and opened on both sides and the weight of the exit sign caused it to slip out of place. During an interview, ADOC #111,and the Director of ES #110 both observed the sign and confirmed that it should not be displaced, and the ceiling tiles should not be cracked on both sides. He/she also confirmed that there was no entry into the automated work requisition system related to the falling exit sign.

On an identified date while conducting observations on an identified floor, the inspector observed the following maintenance concerns:

In a resident room, there were three 20 cm x 4 cm holes in the dry wall behind bed #2. During an interview, registered staff RN #182 stated that the wall should be repaired and confirmed that he/she would enter the area of disrepair into the automated work requisition system.

On an identified floor, beside the north corridor exit, a strip of base board loosely hung from the base yielding a sharp edge with the potential to harm residents. During an interview, maintenance worker #176 was made aware and confirmed that the strip from the baseboard could be potential harm to residents; and that it should not be hanging loosely from the baseboard.

During an interview, the home’s Director of ES #110 stated it was the expectation that all staff working in the home observe for uncleaned, disrepair and broken furniture, walls and equipment and enter the information into the automated work requisition system so

that housekeeping and maintenance staff became aware of the repair and cleaning required to maintain the home. In addition, the Director of ES displayed by computer multiple work requisitions entered by staff from an identified period; and provided a printed document with an identified date, which indicated a sample of the areas of disrepair in the home which was entered into the automated work requisition system.

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with multiple compliance orders and a previous Director Referral. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

On an identified date while conducting a maintenance observation in the home related to follow up compliance order, inspector #535 and #502 observed the environmental air temperature within the home to be excessively warm during an Environmental Canada heat alert.

Inspectors reviewed residents' home areas and cooling areas air temperatures and random residents' room temperatures using the posted portable thermometers located on the walls or desk tops in the nurses' station on each floor. The following information was observed on the floors:

On an identified floor, the nurses station and in the lounge area in front of the nurses' station where residents gathered sitting in their wheelchair was 48% humidity with air temperature of 29 degrees Celsius. According to staff, the dining room was considered the required cooling area with a recorded of humidity 51% and temperature of 29 degrees Celsius. One resident room had a recorded humidity of 47% and temperature of 29 degrees Celsius. Therefore, the identified floor did not have a cooling area as confirmed by multiple staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On an identified floor, the south corridor was observed to be humidity 50% and the temperature was 28.8 degrees Celsius. An identified resident's room, the nurses' station, and the dining room recorded the same humidity at 44% and temperature of 29 degrees Celsius. Registered staff RN #189 confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by register staff RN #189 since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On another identified floor, the north end corridor recorded humidity of 53% and temperature of 29 degrees Celsius. The nurses' station and dining room was observed to be humidity of 46% and temperature of 30 degrees Celsius. Therefore, the identified floor did not have a cooling area as confirmed by multiple staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On another identified floor, the south corridor recorded humidity of 45% and temperature of 30.4 degrees Celsius and the dining room and nurses' station recorded humidity of 54% and temperature of 29 degrees Celsius. The inspector observed that PSWs were providing residents with popsicles and additional fluids. PSW #103 confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by PSW #103 since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open

which would account for the consistency in temperature throughout the unit.

On another identified floor, there was no thermometer posted in the south corridor. However, the nurses' station, dining room where approximately 20 residents were engaged in an activity, and the resident lounge area immediately in front of the nurses' station recorded humidity of 35% and temperature of 29 degrees Celsius. Multiple staff members confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

During interviews, resident #001, #027, and #028 confirmed that the air temperatures in their rooms were hot; and resident #028, who was listed as high risk on the Heat Risk Assessment form, added that he/she felt miserable and the heat was causing discomfort, however, analgesic was already offered related to the discomfort.

The inspectors also noted that the home did not make an announcement to alert all staff to implement the heat contingency protocol on this date until later in the afternoon; after which time it was noted that additional popsicle and fluids were brought to the unit for distribution. After the observation, inspectors updated the home's Executive Director #145 related to the findings; and requested staff confirmation of the actual temperatures on each floor and designated cooling areas which was confirmed to be the dining room on each floor.

On an identified date, the Acting DOC provided written confirmation of the temperatures on each floor which included the dining rooms, and confirmed that there were no available cooling areas on all identified floors and that the doors to the dining room were kept open. Furthermore, he/she confirmed that the designated cooling areas in the home were the dining room, however cooler temperature was not maintain the dining room.

During an interview, the home's Director of ES #110 stated that the expectation was for reception to make an announce as soon as possible to alert staff to implement the heat contingency protocol; for maintenance workers to ensure all malfunctioning air conditioning units were fixed and operational on the floors; for the dining room doors to be kept closed to provide a cooling area for residents, and for staff to close window curtains and turn lights down in non-occupying areas to maintain cooler temperatures on the units.

During an interview, the Acting Director of Care #111 agreed with the above strategies, as well the expectation was that direct care staff members monitor all residents, especially those designated high risk, closely to avoid heat emergencies; and provide extra fluids and keep resident in cooling area.

The severity of Harm was minimum harm/risk or potential for actual harm/risk; the scope was widespread; and the compliance history revealed ongoing non-compliance with voluntary plan of compliance and compliance order. [s. 20. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of an identified CIR (Critical Incident Report) revealed that on an identified date, resident #016 sustained a fall which resulted in an injury for which the resident was transferred to hospital.

Record review revealed resident #016 was assessed by the Minimum Data Set to never or rarely made decisions. A review of the physiotherapist assessment revealed that the resident required the use of a Hoyer lift for transferring from bed to chair. Record review revealed and staff interview confirmed that on an identified date, PSW #196 and #207 were in the process of transferring the resident from bed to wheelchair using the Hoyer lift and a large sling as documented in the residents care plan, when the resident slid and experienced a fall.

During an interview, PSW #196 stated that the resident was placed on the sling with some challenges; as well, the PSW stated that the resident had lost some weight and the sling might have been too big.

During an interview, registered staff #106 RN and PRN #155 confirmed that the incident occurred and provided first aid to the resident. The physician and family were notified and the resident was transferred to an acute care hospital.

During an interview, the ADOC #107 confirmed the incident occurred, and stated that upon arrival in the room immediately after the incident he/she observed that the size of the sling was not appropriate for the resident and immediately changed the sling being used from a large to a medium, and requested the resident's care plan be updated. During an interview, the Acting DOC #111 stated that the resident was assessed for the appropriate sling size at admission and although weight loss was being monitored by registered staff related to food and nutrition; there was a gap in monitoring residents with weight gain/loss related to sling sizing. [s. 36.]

2. A review of an identified CIR (Critical Incident Report) revealed that on an identified date resident #017 sustained a fall during a transfer.

Record review revealed resident #017 was assessed by the Minimum Data Set to be independent with consistent and reasonable decision-making. A review of the physiotherapist assessment revealed that the resident required the use of a Hoyer lift for transferring from bed to chair; and the use of a Hygienic sling for toileting. Record review revealed that on an identified date, PSW #108 and #206 were in the process of transferring the resident from the commode chair to the bed while using the Hygienic sling as documented in the resident's care plan, when the resident slid and experienced a fall onto the top of the bed.

During an interview, resident #017 stated that after toileting both PSWs connected the sling to the Hoyer lift at the bedside, and attempted to elevate the lift to transfer the resident to bed; however, during the transfer, the resident started to slip and alerted the PSWs that he/she was going to fall. At that time PSW #108 who was controlling the lift, briskly positioned the resident over the bed and use the control to let the resident down on the bed quickly.

During an interview, PSW #108 confirmed reporting the resident's pain to registered staff #207 immediately after the resident was transferred back to bed. During separate

interviews, both PSW #108 and #206 denied the incident occurred; and described the mechanical transfer as conducted smoothly. During the interview, the resident stated that he/she believed that PSW #108 may not have understood the best way to apply the Hygienic sling.

During an interview, registered staff RPN #207 confirmed PSW #108 reported the resident was experiencing discomfort; and that he/she administered analgesic but was not informed by the PSW or the resident that an incident had occurred during the transfer.

During an interview, Acting DOC #111 stated that he/she believed the incident occurred because the resident was able to describe the incident with great details on four separate occasions; and the resident required transfer to the acute care hospital for assessment and treatment with medication prescribed upon return to the home. According to the Acting DOC, the PSW was disciplined related to unsafe transfer of a resident causing injury.

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with multiple compliance orders and a previous Director Referral. [s. 36.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked.

On an identified date, observation by the inspector revealed the rear fire door leading outside to the residents' courtyard was propped open with a piece of wood. Once inside, this door leads directly to a non-residential area and the staircase to the basement. The fire door does not have a handle on the exterior; and does not have an access code for engagement as per the fire department instructions; therefore residents would not be able to access the building from the outside, except if the door was propped open.

During the incident, it was observed that a resident was sitting outside in the gazebo, and one other resident was sitting in the courtyard. The inspectors alerted the Director of Food Services #192 and the Food Service Supervisor #193, who both witnessed the door propped open and confirmed that the door should not have been propped open and left unattended and unsupervised.
PLEASE NOTE: This evidence of non-compliance was found during inspection #2017_630589_0015.

2. During the inspection observations by the inspectors revealed resident #023 and #024 had access to a non-residential area of the home.

On an identified date, resident #023, and on another identified date, resident #024, were observed accessing the rear of the building in the non-residential area unescorted beyond the dining room door, to use the back elevator.

During separate interviews, both residents confirmed that they accessed the non-residential area to use the back elevator quite often; however both stated that a staff member usually enters the access code so that they could gain access to the area and use the back elevator because the wait time for the main elevators was too long.

During an interview, the Director of Food Services #192 confirmed that he/she sometimes entered the access code and open the door for residents to access the rear non-residential area to use the back elevator to the basement.

During an interview, the Director of Environmental Services #110 confirmed that residents should not be accessing the rear non-residential area of the building or using the back elevator for access to the basement because these non-residential areas may pose a risk to residents.
PLEASE NOTE: This evidence of non-compliance related to resident #023 and #024 was found during inspection #2017_630589_0015. [s. 9. (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 all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date, while conducting observation related to a follow up inspection, the inspector was notified that the tuck shop did not have a call bell.

During an interview, the inspector was notified that there had been at least two emergency incidents which required the use of a call bell; that the Acting Executive Director (ED) #149 was informed of the lack of a call bell in the tuck shop; and that management had not yet responded regarding the issue.

During an interview, the Director of ES #110 stated that he/she was not aware that there was no call bell system in the residents' tuck shop; however, he/she was aware that there was no resident call bell system available outside in the residents' courtyard. Furthermore, the Director of ES confirmed that both areas should have call bell systems in place and will therefore contact the vendor to get a quote and work to resolve the issue. [s. 17. (1) (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 the resident-staff communication and response system is easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On an identified date while conducting observation related to a follow up inspection, the inspector observed the following concerns:

On an identified floor, shower room #1 was observed to have unlabeled, communal items located on the counter top near the sink – three bottles of skin lotions, one bottle of shampoo, and one bottle of roll-on deodorant.

On another identified floor, shower room #2 was observed to have unlabeled, communal items located on the personal support cart stored in the shower room – one shaving cream, one blue razor blade, one bottle of skin location. During an interview, PSW #109 stated the personal items should be labeled and stored securely in the residents' rooms for use during individualized personal care.

In an identified ward bedroom, the inspector observed the following unlabeled personal items located on the counter top near the sink – shaving cream, k-basin with two tooth brushes and two tubes of tooth paste, one fluoride tooth paste, a bar of soup in an open

soap dish. During an interview, PSW #190 acknowledged that all personal items should have been labeled with resident's name and room number.

On another identified floor, shower room # 2 was observed to have unlabeled, communal items located on the counter top near the sink – two cans of shaving cream and one bottle of skin lotion. During an interview, PSW #175 stated those items should have been labeled with resident's name and room number, and safely stored in the resident room.

On another identified floor, while observing the semi-private bedroom, the inspector observed unlabeled personal items located on the counter top near the sink - two toothbrushes, one denture cup and one fluoride toothpaste. During an interview, the ADOC #111 stated that personal items should be labeled and safely stored in resident's individual drawer/cupboard.

On an identified date, while conducting observation related to a follow up inspection, on the second floor, shower room #2, the inspector observed unlabeled, communal items located on the counter top near the sink – three cans of shaving cream and one tube of barrier cream. During an interview, PSW #191 stated that personal items should have been labeled with the resident names and room number and stored safely in the resident room.

During an interview, ADOC #111 and lead for the home's infection prevention and control (IPAC) stated that the expectation was all resident personal items were to be labeled with the resident's name and room number; and safely stored in the resident room inside their personal drawer/cupboard. The IPAC lead confirmed that direct care providers did not participating in the home infection control practices. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of an identified CIR (Critical Incident Report) revealed that resident #016 sustained a fall which resulted in an injury and transfer to hospital.

Record review revealed resident #016 was assessed by the Minimum Data Set to never or rarely made decisions. A review of the physiotherapist assessment revealed that the resident required the use of a Hoyer lift for transferring from bed to chair. Record review revealed and staff interview confirmed that on an identified date, while PSW #196 and #207 was transferring resident #016 from bed to wheelchair using the Hoyer lift and sling, the resident slid and fell.

Record review revealed that the resident was transferred to hospital and returned to the home on the same day with a specific assessment initiated. A review of the specific assessment revealed that the registered staff did not document the assessment between a designated time period nor signed the document.

During an interview, the ADOC confirmed that the documentation was not completed consistently; and stated that the registered staff should have document the findings of his/her assessment as well as signed the document. [s. 30. (2)]

Issued on this 14th day of November, 2017

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

Original report signed by the inspector.

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) :	VERON ASH (535)
Inspection No. / No de l'inspection :	2017_324535_0014
Log No. / No de registre :	008040-17, 011346-17, 011347-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 27, 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

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:

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure that the home is a safe and secure environment for its residents.

The compliance plan shall include but is not limited to:

1. Develop and implement a process to ensure that staff, visitors, contractors and vendors are made aware of the importance of securing doors in the home which lead to non-residential areas to prevent residents from accessing those area.

2. Conduct assessments to ensure that residents who wish to use the stairwells can do so unsupervised in a safe manner.

3. Develop a plan to ensure all sharp instruments and objects are disposed of immediately after use; and stored safely and securely in an area not accessible to residents.

4. Conduct assessments to ensure that residents who wish to use razor blades or sharp instruments can do so unsupervised in a safe manner.

5. Develop quality improvement initiatives such as audits to ensure doors that are accessible to non-residential areas are kept closed when not in use or properly supervised; and an audit system to ensure sharp instruments and objects are stored in a safe and secure location in the home.

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 objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, October 27, 2017 via email to:
veron.ash@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

This inspection protocol was initiated by the inspector as resident #006 was

observed walking unsupervised in the stairwell.

On an identified date, the inspector observed resident #006, who was unsupervised and unaccompanied, enter the code into the keypad of the door located on an identified floor and walk down the stairwell to the ground floor. This observation was brought to the attention of the Acting DOC #111 who then directed the ESM to immediately change the code to the door leading to that stairway.

On an identified date, the inspector observed resident #006, who was unsupervised and unaccompanied, enter the code into the keypad of the door and walked up the stairwell to his/her assigned floor. This observation was brought to the attention of NM #156 who stated that the code to this door had been changed two days ago and that resident #006 had been advised to use the elevator; the NM stated that furthermore, the resident may have gotten the access code from a family member during the recent visit.

In an interview, resident #006 stated that he/she prefers to use the stairwell because the elevators were sometimes busy. The resident further stated that staff members were aware of his/her use of the stairwell and were upset with him/her for doing so.

In interviews, PSW #161 and RPN #127 stated that resident #006 always takes the elevator unsupervised, however they were unsure if the resident was assessed by the physiotherapist prior to doing so. In an interview, PT #102 stated that he/she had observed resident #006 walking down the staircase on multiple occasions, but he/she had not assessed or cleared the resident to use the stairs.

In interviews, the Acting DOC #111 stated that prior to using the stairwell independently; resident #006 should have been assessed and cleared to do so by the PT #102. The home failed to demonstrate that they provided a safe and secure environment because resident #006 was provided the access codes and was able to walk up and down the stairs unsupervised. Further to this assessment, staff members should have considered the resident's level of understanding potential risk to self and others and ensure the doors were secured after exiting and entering.
PLEASE NOTE: This evidence of non-compliance related to resident #002 was found during inspection #2017_632502_0013. (535)

2. On an identified date, a critical incident was submitted to the MOHLTC related to an injury of resident #002. Review of the critical incident and progress notes revealed that on an identified date and time, a personal support worker (PSW) found resident #002 in his/her room with the injury.

In an interview, resident #002 stated that he/she told recreation staff which recreational activities that he/she was interested in doing. Recreation staff told him/her to follow the home's activities calendar because it was based on Montessori teaching. Resident #002 stated that before he/she was injured on the date identified, he/she told recreation staff that he/she was had nothing to do in the home. Resident #002 further stated that he/she found sharp objects on the linen cart in the hallway which was available on each floor.

Review of MDS assessment revealed that resident #002 was consistent and reasonable with daily decision making abilities. A review of resident #002's most recent written plan of care revealed multiple related diagnosis; and interventions implemented directed staff to check the resident's room every shift; and to remove all sharp objects.

The inspector conducted observations on other units to observe for sharp objects and found the following:

- On an identified date, the inspector observed a sharp object unsupervised on the linen cart in the hallway of the third floor South. PSW #182 told the inspector that he/she had left the sharp object in that location as he/she was going to shower a resident after lunch.
- On the same date, the inspector observed four sharp objects left unsupervised on the linen cart in the hallway of the third floor South. PSW #125 told the inspector that he/she had left the sharp object in that location.
- On another identified date, the inspector observed four sharp objects left unsupervised on the linen cart in the hallway on the fifth floor North.

During an interview, NM #128 stated that staff members have been trained to remove sharp objects and other unsafe objects from the linen cart as soon as they were finished using them. NM#128 acknowledged that leaving sharp objects unsupervised in the linen cart in the hallway had not ensured a safe environment for the residents.
PLEASE NOTE: This evidence of non-compliance related to resident #002 was

found during inspection #2017_632502_0014. [s. 5.] (535)

3. On an identified date while conducting follow up observations on an identified floor, the inspector observed the following incident:

The inspector observed resident #025 wandering to the North corridor of the fourth floor unit and exit seeking by pushing against the door. At that same time, housekeeping staff #200 was walking the staircase to an upper floor when he/she noticed contractor #184 exited the fourth floor unit door, with resident #025 standing immediately inside the unit and started pushing on the exit door. Contractor #184 left the area without waiting for the exit door magnetic lock to re-engage therefore not securing the unit before leaving the area.

During an interview, housekeeping staff #200 stated that he/she saw the resident standing inside the door and stopped at the door to ensure the resident did not get out the door and into the staircase. The staff stated that he/she tried to remind the contractor to ensure the magnetic lock was engaged at the door before going down the staircase; however, he/she did not wait to listen to the message. The housekeeping staff further stated that he/she would advise the supervisor of the incident.

During an interview, the Director of ES #110 stated that all contractors received education and training related to working with resident on the units; and that he/she would meet with contractor #184 and remind him/her of the importance of waiting until the magnet lock was engaged before leaving the exit door and going downstairs. The Director of ES confirmed that the incident could have potentially compromised the safety and security of resident #025 if he/she had gone outside the exit door and into the staircase. [s. 5.]

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with a voluntary plan of compliance or compliance order. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 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. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The compliance plan shall include but is not limited to:

1. Develop and implement a process to ensure all staff working in the home to observe for unclean and disrepair furnishings, walls and equipment and reporting the same immediately in person to management or by entering the required information in the home's automated requisition system (maintenance computer system); to ensure repairs are completed in a timely manner and the home, furnishings and equipment are maintained in safe condition and in a good state of repair.

2. Develop/redevelop and implement a policy or procedure to address how work is prioritize to effectively and efficiently address maintenance and housekeeping concerns identified by staff and entered into the automated requisition system (maintenance computerized system) on a daily basis.

3. Develop and implement quality improvement initiatives such as audits to ensure maintenance and housekeeping staff participate in the day to day process of maintaining the home in safe condition and a good state of repair.

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 objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, October 27, 2017 via email to:
veron.ash@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On an identified date while conducting observations related to a follow up inspection, the inspector observed the following areas of concerns:

On an identified floor, shower room #2 was observed to have a removal of a

piece of the ceiling tiles with size approximately 20 cm x 20 cm and the open area was covered with a piece of orange plastic sheet. During an interview, the maintenance worker # 176 who entered the shower for repair work informed the inspector that the leakage was a result of condensation from the pipes in the ceiling. On the opposite side of the partition wall the ceiling tile remained intact however the tile had orange water marks and a few small areas with black mold-like substance identified and this was confirmed by the maintenance worker during an observation.

On another identified floor, while observing a resident's room listed in the previous follow up inspection, resident #026 requested that the inspector observe the large hole in his/her washroom. The inspector observed a 15 cm x 15 cm hole in the dry wall in the corner below the lever of the toilet, with exposed pipes and dust debris observed in the open area. The resident voiced concerns related to not knowing what he/she was breathing from the opening in the wall. During an interview, the Direct of Environmental Services (ES) #110 confirmed that the area of disrepair was not entered into the automated work requisition system for repair.

On another identified floor, the inspector observed an identified resident's room, although the previous area identified in the report was repaired, a new area of disrepair was identified related to the ceiling tile directly inside the washroom door appeared to be falling/bulging. During an interview, the Director of ES #110 informed the inspector that the reason for the bulging was because the ceiling tile did not fit the open area in the ceiling; and he/she confirmed that the ceiling tile should have been fixed, and that the bulging ceiling tile was not entered into the automated work requisition system for repair.

On an identified date, inspector #605 observed a large hole in the drywall to the lower portion of the washroom wall inside the entrance of room #515. During an interview, the Director of ES #110 confirmed that the dry wall disrepair was not entered into the automated work requisition system for repair; however, on another identified date, the maintenance worker completed the drywall repair.

On an identified floor, immediately outside shower room # 2 in the common hallways, the inspector observed a illuminated exit sign was hanging lower than normal. With closer observation, it was discovered that the ceiling tile which held the exit sign in place was broken and opened on both sides and the weight of the exit sign caused it to slip out of place. During an interview, ADOC #111,and

the Director of ES #110 both observed the sign and confirmed that it should not be displaced, and the ceiling tiles should not be cracked on both sides. He/she also confirmed that there was no entry into the automated work requisition system related to the falling exit sign.

On an identified date while conducting observations on an identified floor, the inspector observed the following maintenance concerns:

In a resident room, there were three 20 cm x 4 cm holes in the dry wall behind bed #2. During an interview, registered staff RN #182 stated that the wall should be repaired and confirmed that he/she would enter the area of disrepair into the automated work requisition system.

On an identified floor, beside the north corridor exit, a strip of base board loosely hung from the base yielding a sharp edge with the potential to harm residents. During an interview, maintenance worker #176 was made aware and confirmed that the strip from the baseboard could be potential harm to residents; and that it should not be hanging loosely from the baseboard.

During an interview, the home's Director of ES #110 stated it was the expectation that all staff working in the home observe for uncleaned, disrepair and broken furniture, walls and equipment and enter the information into the automated work requisition system so that housekeeping and maintenance staff became aware of the repair and cleaning required to maintain the home. In addition, the Director of ES displayed by computer multiple work requisitions entered by staff from an identified period; and provided a printed document with an identified date, which indicated a sample of the areas of disrepair in the home which was entered into the automated work requisition system.

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with multiple compliance orders and a previous Director Referral.
(Compliance History: #1 Director Referral from inspection report # 2017_644507_0003, dated March 7, 2017; #2 Compliance Order from inspection report # 2016_353589_0016, dated August 3, 2016; #3 Compliance Order # 2016_226192_0013, dated April 4, 2016). (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2017

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensures that if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents.

The compliance plan shall include but is not limited to:

1. Develop and implement a plan to ensure air temperatures and humidity are consistently monitored and recorded when warranted; and the home makes prompt announcement to implement the heat contingency plan to minimize the risk of heat related illnesses.

2. Develop and implement a plan to ensure the home has at least one separate designated cooling areas for every 40 residents.

3. Develop and implement quality improvement initiatives such as audits to ensure the heat contingency plan is implemented and maintained when warranted.

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 objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, October 27, 2017 via email to:
veron.ash@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that if central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

On an identified date while conducting a maintenance observation in the home related to follow up compliance order, inspector #535 and #502 observed the environmental air temperature within the home to be excessively warm during an Environmental Canada heat alert.

Inspectors reviewed residents' home areas and cooling areas air temperatures and random residents' room temperatures using the posted portable thermometers located on the walls or desk tops in the nurses' station on each floor. The following information was observed on the floors:

On an identified floor, the nurses station and in the lounge area in front of the nurses' station where residents gathered sitting in their wheelchair was 48% humidity with air temperature of 29 degrees Celsius. According to staff, the dining room was considered the required cooling area with a recorded of humidity 51% and temperature of 29 degrees Celsius. One resident room had a recorded humidity of 47% and temperature of 29 degrees Celsius. Therefore, the identified floor did not have a cooling area as confirmed by multiple staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On an identified floor, the south corridor was observed to be humidity 50% and the temperature was 28.8 degrees Celsius. An identified resident's room, the nurses' station, and the dining room recorded the same humidity at 44% and temperature of 29 degrees Celsius. Registered staff RN #189 confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by register staff RN #189 since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On another identified floor, the north end corridor recorded humidity of 53% and temperature of 29 degrees Celsius. The nurses' station and dining room was

observed to be humidity of 46% and temperature of 30 degrees Celsius. Therefore, the identified floor did not have a cooling area as confirmed by multiple staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On another identified floor, the south corridor recorded humidity of 45% and temperature of 30.4 degrees Celsius and the dining room and nurses' station recorded humidity of 54% and temperature of 29 degrees Celsius. The inspector observed that PSWs were providing residents with popsicles and additional fluids. PSW #103 confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by PSW #103 since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

On another identified floor, there was no thermometer posted in the south corridor. However, the nurses' station, dining room where approximately 20 residents were engaged in an activity, and the resident lounge area immediately in front of the nurses' station recorded humidity of 35% and temperature of 29 degrees Celsius. Multiple staff members confirmed that the cooling area on the floor was designated the dining room. Therefore, the identified floor did not have a cooling area as confirmed by staff since the temperatures were consistently the same. The inspectors observed that the dining room door was kept open which would account for the consistency in temperature throughout the unit.

During interviews, resident #001, #027, and #028 confirmed that the air temperatures in their rooms were hot; and resident #028, who was listed as high risk on the Heat Risk Assessment form, added that he/she felt miserable and the heat was causing discomfort, however, analgesic was already offered related to the discomfort.

The inspectors also noted that the home did not make an announcement to alert all staff to implement the heat contingency protocol on this date until later in the afternoon; after which time it was noted that additional popsicle and fluids were brought to the unit for distribution. After the observation, inspectors updated the home's Executive Director #145 related to the findings; and requested staff confirmation of the actual temperatures on each floor and designated cooling areas which was confirmed to be the dining room on each floor.

On an identified date, the Acting DOC provided written confirmation of the temperatures on each floor which included the dining rooms, and confirmed that there were no available cooling areas on all identified floors and that the doors to the dining room were kept open. Furthermore, he/she confirmed that the designated cooling areas in the home were the dining room, however cooler temperature was not maintain the dining room.

During an interview, the home's Director of ES #110 stated that the expectation was for reception to make an announce as soon as possible to alert staff to implement the heat contingency protocol; for maintenance workers to ensure all malfunctioning air conditioning units were fixed and operational on the floors; for the dining room doors to be kept closed to provide a cooling area for residents, and for staff to close window curtains and turn lights down in non-occupying areas to maintain cooler temperatures on the units.

During an interview, the Acting Director of Care #111 agreed with the above strategies, as well the expectation was that direct care staff members monitor all residents, especially those designated high risk, closely to avoid heat emergencies; and provide extra fluids and keep resident in cooling area.

The severity of Harm was minimum harm/risk or potential for actual harm/risk; the scope was widespread; and the compliance history revealed ongoing non-compliance with voluntary plan of compliance and compliance order. (535)

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2017_644507_0003, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will ensure staff use safe transferring and positioning devices or techniques when assisting residents.

The compliance plan shall include but is not limited to:

1. Develop and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting residents.

2. Develop and implement a policy or procedure (or include in current weight monitoring policy) to ensure monthly reassessment of residents exhibiting significant weight changes and who were assessed by the physiotherapist to require a mechanical lift for transfer; to ensure the size of sling and type of mechanical lift are appropriate for safe transfers.

3. Develop and implement a plan to ensure all direct care staff become familiar with the difference in use and application of the high back sling and the hygienic sling used in the home.

4. Develop and implement quality improvement initiatives such as audits to ensure the policy/procedure related to monthly reassessment of residents exhibiting significant weight changes and assessed by the physiotherapist to use a mechanical lifts, is effectively implemented.

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 objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, October 27, 2017 via email to:
veron.ash@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of an identified CIR (Critical Incident Report) revealed that on an identified date resident #017 sustained a fall during a transfer.

Record review revealed resident #017 was assessed by the Minimum Data Set to be independent with consistent and reasonable decision-making. A review of the physiotherapist assessment revealed that the resident required the use of a Hoyer lift for transferring from bed to chair; and the use of a Hygienic sling for toileting. Record review revealed that on an identified date, PSW #108 and #206 were in the process of transferring the resident from the commode chair to the bed while using the Hygienic sling as documented in the resident's care plan, when the resident slid and experienced a fall onto the top of the bed.

During an interview, resident #017 stated that after toileting both PSWs connected the sling to the Hoyer lift at the bedside, and attempted to elevate the lift to transfer the resident to bed; however, during the transfer, the resident started to slip and alerted the PSWs that he/she was going to fall. At that time PSW #108 who was controlling the lift, briskly positioned the resident over the bed and use the control to let the resident down on the bed quickly.

During an interview, PSW #108 confirmed reporting the resident's pain to registered staff #207 immediately after the resident was transferred back to bed. During separate interviews, both PSW #108 and #206 denied the incident occurred; and described the mechanical transfer as conducted smoothly. During the interview, the resident stated that he/she believed that PSW #108 may not have understood the best way to apply the Hygienic sling.

During an interview, registered staff RPN #207 confirmed PSW #108 reported the resident was experiencing discomfort; and that he/she administered analgesic but was not informed by the PSW or the resident that an incident had occurred during the transfer.

During an interview, Acting DOC #111 stated that he/she believed the incident occurred because the resident was able to describe the incident with great details on four separate occasions; and the resident required transfer to the acute care hospital for assessment and treatment with medication prescribed upon return to the home. According to the Acting DOC, the PSW was disciplined related to unsafe transfer of a resident causing injury. (535)

2. A review of an identified CIR (Critical Incident Report) revealed that on an identified date, resident #016 sustained a fall which resulted in an injury for which the resident was transferred to hospital.

Record review revealed resident #016 was assessed by the Minimum Data Set to never or rarely made decisions. A review of the physiotherapist assessment revealed that the resident required the use of a Hoyer lift for transferring from bed to chair. Record review revealed and staff interview confirmed that on an identified date, PSW #196 and #207 were in the process of transferring the resident from bed to wheelchair using the Hoyer lift and a large sling as documented in the residents care plan, when the resident slid and experienced a fall.

During an interview, PSW #196 stated that the resident was placed on the sling with some challenges; as well, the PSW stated that the resident had lost some weight and the sling might have been too big.

During an interview, registered staff #106 RN and PRN #155 confirmed that the incident occurred and provided first aid to the resident. The physician and family were notified and the resident was transferred to an acute care hospital.

During an interview, the ADOC #107 confirmed the incident occurred, and stated that upon arrival in the room immediately after the incident he/she observed that the size of the sling was not appropriate for the resident and immediately changed the sling being used from a large to a medium, and requested the resident's care plan be updated. During an interview, the Acting DOC #111 stated that the resident was assessed for the appropriate sling size at admission and although weight loss was being monitored by registered staff related to food and nutrition; there was a gap in monitoring residents with weight gain/loss related to sling sizing. [s. 36.]

The severity of Harm was actual harm/risk; the scope was isolated; and the compliance history revealed ongoing non-compliance with multiple compliance orders and a previous Director Referral.
Compliance History: #1 Director Referral #2017_644507_0003, dated March 7, 2017; #2 Compliance Order # 2016_353589_0016, dated August 3, 2016; and #3 Compliance Order #2015_324567_0016, dated November 30, 2015). (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2017

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 27th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Veron Ash

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