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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2018	2017_420643_0024	029683-17	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd. Suite 300 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

ADAM DICKEY (643)

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): December 28, 29, 2017, and January 3, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director(s) of Care (DOC), Environmental Services Manager (ESM), Building Services Partner (BSP), Building Services Project Manager (BSPM), Director of Food Services, Food Services Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Maintenance Aide (MA), Dietary Aides, and residents.

During the course of the inspection the inspector conducted temperature observations and measurement, observation of building services and electrical room, reviewed records, relevant policies and procedures and emergency plans.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 19. Generators

Specifically failed to comply with the following:

s. 19. (1) Subject to subsections (2) to (4), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage,
(a) the heating system; O. Reg. 79/10, s. 19 (1).
(b) emergency lighting in hallways, corridors, stairways and exits; and O. Reg. 79/10, s. 19 (1).
(c) essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment. O. Reg. 79/10, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was served by a generator that was available at all times and that had the capacity to maintain the heating system in the event of a power outage.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding the temperature of areas of the home following a power outage in the home on December 27, 2017. The complaint indicated there was no heat in the building during the power outage.

In an interview, Director of Care (DOC) #100 stated that there had been a power outage on December 27, 2017, which lasted for approximately one hour. DOC #100 stated that the generator had come on and emergency lighting was operational as well as one elevator. DOC #100 was unable to verify if the heating system was operational.

In an interview, Maintenance Aide (MA) #101 stated that the generator that is in place in the home does not supply power to the heating system in the event of a power outage. MA #101 stated that the generator only supplied power to one electrical service panel in the administration office on the first floor of the home. MA #101 stated this electrical service panel provided power to emergency lighting, staff and resident communication systems, emergency outlets, but would not supply power to the heating system throughout the home.

Review of the electrical service panel located in the administration office located behind

reception on the first floor of the home failed to reveal any electrical connection to the heating system with the exception of Packaged Terminal Air Conditioner (PTAC) units in the garden lounge and tuck shop.

In an interview, Building Services Project Manager (BSPM) #112 stated that the on-site generator was installed when the Long-Term Care home had been converted from condominiums. BSPM #112 stated that the main source of heating in the building was the PTAC units. BSPM #112 additionally stated that the make-up air system which provides some heating to the building was not connected to the generator. BSPM #112 stated that the building services team was working on finding electrical diagrams for the generator but was unable to produce them.

Observations conducted with ESM #110 in the electrical room in the basement level of the home failed to reveal any electrical diagrams or schematics indicating what is supplied by the on-site generator. There were no electrical boxes leading from the generator labeled heating system or PTAC units found.

In interviews, ESM #110, BSP #102 and BSPM #112 stated that the heating system in the home should be powered by the generator but could not provide any documentation to show what building services were supplied by the generator power. BSPM #112 acknowledged that no documentation was available to show the generator had the capacity to maintain the heating system in the event of a power outage.

The severity of this noncompliance was identified as potential for actual harm, the scope was widespread as it affected all residents in the home. A review of the home's compliance history revealed no prior noncompliance was issued related to O. Reg. 79/10, s. 19 (1). Due to the severity and scope of this noncompliance a compliance order is warranted. [s. 19. (1) (a)]

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 O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding the temperature of areas of the home following a power outage in the home on December 27, 2017. The complaint indicated there was no heat in the building during the power outage.

Observations by the inspector were conducted in the main dining room on the ground floor of the home with MA #101 on December 28, 2017, at 1454 hours. Several portable heaters had been plugged in to wall outlets throughout the dining room and were operating. Air temperature of the main dining room was measured using a Reed LM 81HT hand-held thermometer which read 20.0 degrees Celsius (C) near the doorway to the dining room and 20.2 degrees C at table number eight near the windows.

Review of Midland Gardens Air Temperature monitoring records revealed the temperature in the main dining room on the ground floor of the home had been below 22 degrees C on the following dates:
- December 14, 2017, at 1230 hours main dining room 20.7 degrees C;
- December 15, 2017, at 1030 hours main dining room 20.5 degrees C;
- December 17, 2017,at 0950 hours main dining room 20.9 degrees C;
- December 26, 2017, at 0940 hours main dining room 21.6 degrees C; and
- December 28, 2017, at 1210 hours main dining room 21.6 degrees C.

Interviews were conducted with several residents in the main dining room on December 28, 2017, between 1615 and 1625 hours. Resident #007 stated that it has been cold in the dining room for the last couple of days, and had been comfortable prior to the colder weather outside. Resident #007 stated that staff were asking residents to wear coats if they were cold. Resident #002 stated that they had found it cold in the dining room. Resident #003 stated that it was chilly in the dining room because the door was open, but was comfortable enough wearing a sweater.

In interviews, Dietary Aides #108 and #109 stated that it was colder in the dining room over the last two to three days. The dietary aides both stated that residents in the dining

room had been complaining that it was cold, and was colder when the door to the dining room was open.

Observations by the inspector on December 29, 2017, at 1016 hours revealed temperature measured using a Reed LM 81HT hand-held thermometer which read 21.3 degrees C at table 23 near the entrance to the dining room. Temperature was measured at table 14 near the windows revealing a temperature of 20.6 degrees C. Temperature was observed at 1202 hours at table 22 near the windows to be 21.7 degrees C. Resident #005 was sitting at a dining table wearing a winter jacket and gloves and stated that he/she was cold in the dining room. Resident #001 was seated at a dining table and stated it was cold in the dining room. The temperature was measured to be 21.5 degrees C at 1206 hours at table 24 near the entrance to the dining room.

In an interview, MA #101 stated that the process in the home was to measure and record the temperature daily in the North, South, and dining rooms on each floor of the home. MA #101 further stated that the handheld thermometer was used to record temperatures or the wall digital thermometers were used where available in the home. MA #101 stated that the temperature in the dining room had been difficult to maintain at 22 degrees C as the doors to the receiving dock and front entrance to the home allowed cold air into the dining room.

In an interview, Building Services Partner (BSP) #102 stated that the make up air units in the kitchen and dining room area had been turned off previously as the kitchen staff were getting too hot. BSP #102 additionally stated that fans for the Packaged Terminal Air Conditioner (PTAC) units in the dining room were on too high, causing the air to not warm effectively and blow cooler air into the area.

In an interview, DOC #100 stated that he/she had become aware of the temperature in the main dining room of the home was less than 22 degrees C on the morning of December 28, 2017, and contacted BSP #102 to come in to the home to look into the issue. DOC # 100 stated that he/she was not aware of previous temperatures in the dining room being below 22 degrees C. The DOC acknowledged that the home had failed to maintain the air temperature in the dining room at 22 degrees C. [s. 21.]

Ontario

Ministry of Health and Long-Term Care

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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

Issued on this 29th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2017_420643_0024
Log No. / No de registre :	029683-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 29, 2018
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd., Suite 300, 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 :	Debbie Fleming

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 19. (1) Subject to subsections (2) to (4), every licensee of a long-term care home shall ensure that the home is served by a generator that is available at all times and that has the capacity to maintain, in the event of a power outage,
(a) the heating system;
(b) emergency lighting in hallways, corridors, stairways and exits; and
(c) essential services, including dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks, the resident-staff communication and response system, elevators and life support, safety and emergency equipment. O. Reg. 79/10, s. 19 (1).

Order / Ordre :

The Licensee must be compliant with O. Reg. 79/10, s. 19 (1). Specifically, the Licensee shall ensure the following is in place for the home:
1. Ensure a documented record exists on site of which building services are maintained by the generator that is available at all times; and
2. Ensure that the home is served by a generator that has the capacity to maintain the heating system in the event of a power outage.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was served by a generator that was available at all times and that had the capacity to maintain the heating system in the event of a power outage.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding the temperature of areas of the home following a power outage in the home on December 27, 2017. The complaint indicated there was no heat in the building during the power outage.

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operational as well as one elevator. DOC #100 was unable to verify if the heating system was operational.

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Review of the electrical service panel located in the administration office located behind reception on the first floor of the home failed to reveal any electrical connection to the heating system with the exception of Packaged Terminal Air Conditioner (PTAC) units in the garden lounge and tuck shop.

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The severity of this noncompliance was identified as potential for actual harm, the scope was widespread as it affected all residents in the home. A review of

the home's compliance history revealed no prior noncompliance was issued related to O. Reg. 79/10, s. 19 (1). Due to the severity and scope of this noncompliance a compliance order is warranted. (643)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 25, 2018

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 29th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Adam Dickey

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