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
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Aug 8, 2016	2016_377502_0013	020404-16	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

JULIENNE NGONLOGA (502)

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): July 21, 22 and 25, 2016

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistant Director of Care (ADOC), Director of Environmental Services.

During the course of the inspection, the inspector observed the doors in the home and reviewed maintenance services policies and procedures

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

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

1 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. 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. 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 non-residential area are locked when they are not being supervised by staff.

During the course of the inspection the inspector observed double doors leading to non-residential areas to be unlocked while not being supervised by staff.

- On a specified date and time, residents were observed unattended in the dining room. The doors between the dining room and service corridor are not secured and the service corridor leads to the parking lot outside.

- On a specified date and time, the inspector observed the service corridor’s door that lead to the outdoor parking lot open, unlocked, and unattended.

Director of Environmental Services indicated that the door is usually left open when the home expects delivery from suppliers.

- On a specified date and time, the inspector observed the door to the "Garbage Room" on the main floor closed but unlocked. A sign was posted instructing staff to keep the door locked at all times.

- On a specified date and time, the inspector observed resident #002 propelling his/her wheelchair independently and trying to open all doors in the South side of the corridor in the basement. Further observation of the area revealed the service elevator did not have a door code to prevent resident from accessing the kitchen, a piece of old air conditioning unit, broken mechanical lifts, and electrical panel room were accessible to the resident that was wandering in the basement corridor.

- The electrical panel room was observed to be closed but not locked on specified dates and time.

Staff was not present in the service corridor at the time of the observation. Resident #002 stated he/she was looking for the exit door to visit his/her spouse. This was brought to the attention of ADOC #112.

Review of resident #002's most recent written plan of care revealed the resident exhibits an identified responsive behaviour related to an identified medical condition. The resident's written plan of care also direct staff to monitor resident's whereabouts.

Interview with the ADOC #112 confirmed the South side of the corridor in the basement was not a residential area and should be locked to restrict unsupervised access by the resident.

Interview with the Director of Environmental Services and Executive Director confirmed these doors were to be locked at all times. The licensee told the inspector that they are in the process of installing the magnetic locks on the doors but were unable to specify a time frame for completion.

LTCHA, 2007 s.9.(1) 2 was issued as a compliance order (CO #002) during inspection #2016_226192_0013 on April 25, 2016, with a compliance order date of June 30, 2016. The scope of this finding was a pattern related to three unlocked doors leading to non-residential area. The severity showed minimal harm/risk or a potential for actual/harm risk. The Compliance History Report showed ongoing compliance order. As a result of scope, severity and previous compliance history a re-issue of the compliance order #002 is warranted. [s. 9. (1) 2.]

Additional Required Actions:

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

Issued on this 9th day of August, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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) :	JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2016_377502_0013
Log No. / Registre no:	020404-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 8, 2016
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 :	Sara Rooney

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)

Linked to Existing Order / Lien vers ordre existant: 2016_226192_0013, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall ensure that doors that residents do not have access to are kept closed and locked when not supervised by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential area are locked when they are not being supervised by staff.

LTCHA, 2007 s.9.(1) 2 was issued as a compliance order (CO #002) during inspection #2016_226192_0013 on April 25, 2016, with a compliance order date of June 30, 2016. The scope of this finding was a pattern related to three unlocked doors leading to non-residential area. The severity showed minimal harm/risk or a potential for actual/harm risk. The Compliance History Report showed ongoing compliance order. As a result of scope, severity and previous compliance history a re-issue of the compliance order #002 is warranted.

During the course of the inspection the inspector observed double doors leading to non-residential areas to be unlocked while not being supervised by staff.

- On a specified date and time, residents were observed unattended in the dining room. The doors between the dining room and service corridor are not secured and the service corridor leads to the parking lot outside.

- On a specified date and time, the inspector observed the service corridor's door that lead to the outdoor parking lot open, unlocked, and unattended.

Director of Environmental Services indicated that the door is usually left open when the home expects delivery from suppliers.

- On a specified date and time, the inspector observed the door to the "Garbage Room" on the main floor closed but unlocked. A sign was posted instructing staff to keep the door locked at all times.

- On a specified date and time, the inspector observed resident #002 propelling his/her wheelchair independently and trying to open all doors in the South side of the corridor in the basement. Further observation of the area revealed the service elevator did not have a door code to prevent resident from accessing the kitchen, a piece of old air conditioning unit, broken mechanical lifts, and electrical panel room were accessible to the resident that was wandering in the basement corridor.

- The electrical panel room was observed to be closed but not locked on

specified dates and time.

Staff was not present in the service corridor at the time of the observation. Resident #002 stated he/she was looking for the exit door to visit his/her spouse. This was brought to the attention of ADOC #112.

Review of resident #002's most recent written plan of care revealed the resident exhibits an identified responsive behaviour related to an identified medical condition. The resident's written plan of care also direct staff to monitor resident's whereabouts.

Interview with the ADOC #112 confirmed the South side of the corridor in the basement was not a residential area and should be locked to restrict unsupervised access by the resident.

Interview with the Director of Environmental Services and Executive Director confirmed these doors were to be locked at all times. The licensee told the inspector that they are in the process of installing the magnetic locks on the doors but were unable to specify a time frame for completion. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

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