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 prévue 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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2018	2018_626501_0021	016362-17, 011925-18, 024015-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Midland Gardens Care Community
130 Midland Avenue SCARBOROUGH ON M1N 4E6

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

SUSAN SEMEREDY (501), NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 30, 31, September 4, 5, 6, 7, 10, 13, 17, 19, 20, 21, 24, 25, 26, 28, November 1, 2, 8, 9, 26, 27, 28 2018.

The following intakes were inspected during this inspection:
#016362-17 related to the prevention of abuse and neglect
#011925-18 related to the prevention of abuse and neglect
#024015-18 related to the plan of care

This inspection was conducted concurrently with Complaint Inspection #2018_630589_0011. Written Notifications and Compliance Orders, related to S.O. 2007 c.8 s. 19 (1) and 24 (1) were identified in this Critical Incident Inspection #2018_626501_0021 and have been issued in Complaint Report #2018_630589_0011.

Inspector #673 was onsite for this inspection on September 19, 20, 21, 25 and 26, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Administrative Director of Care (A-DOC), Clinical Director of Care (C-DOC), Nurse Managers (NM), Director of Resident Programs (DRP), Registered staff (RN/RPN), Resident Relations Coordinator (RRC), Registered Dietitian (RD), Occupational Therapist (OT), Physiotherapists (PT), Acting Director of Environmental Services (A-DES), Office Manager (OM), Payroll Coordinator (PC), Medical Doctor (MD), Personal Support Workers (PSW), Housekeeping Aide (HA), Maintenance, Resident Program Team (RPT), Dietary Aide (DA), Scheduling Clerk (SC), Minimum Data Set-Resident Assessment Instrument Coordinator (MDS-RAI-C), receptionist, substitute decision makers (SDM), family members, and residents.

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, and reviewed health records, investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

A review of the home's policy #XXIII-C-10.72-SSLI, titled, "Resident Incident Reporting-Point Click Care (PCC)", revised April 2018, indicated that all incidents involving residents will be reported through Risk Management module in PCC. The charge nurse will initiate an incident in the risk management module. Complete the appropriate incident report form after preliminary determination of the severity of the incident based on the criteria below. Lock and sign their section of risk management once the initial documentation is complete. The Director of Care (DOC) and the Executive Director (ED) review the risk management dashboard for new incidents and conduct an investigation as required. Sign off the risk management upon completion of the investigation. The ED will follow up on resolution of risk area identified.

A review of the Critical Incident System (CIS) report submitted on an identified date, indicated that resident #024 was found without vital signs. The physician was called to pronounce death and completed the medical certificate. The physician called the coroner to attend as the physician noted something unusual.

A review of the resident's progress notes indicated that the resident was received in their bed lying in an identified position with no vitals. According to the PSW, the resident was provided care several times during the shift. The physician saw the resident and called the coroner. The coroner arrived and signed the death certificate with identified medical conditions.

Interview with RPN #143 indicated that the incident occurred at an identified time of the day which was almost time for shift change. The home had transitioned from their old electronic system to the new one and was not sure about the resident incident reporting process at that time. RPN #143 confirmed that the risk management was not completed in PCC.

A review of the resident's clinical record indicated that the home had not complied with the policy as the risk management was not initiated by the registered staff to be reviewed and investigated by the DOC and the ED. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that includes the nature of each verbal or written complaint.

The home submitted a CIS report to the MOHLTC on an identified date. According to the report, resident #009 had communicated with visitor #208 on an identified chat forum and the visitor was abusive. There was previous evidence that resident #009 and visitor #208 had an encounter that was also described as abusive.

Review of an email communication provided by DRP #183 to Inspector #673 indicated that on an identified date, ED #133 received a complaint from resident #009 that visitor #208 had interacted inappropriately. During an interview between Inspector #673 and resident #009, the resident indicated visitor #208 was abusive.

Review of the home's complaint binder for 2017 indicated a complaint response form was not completed regarding the above mentioned incident. During an interview with ED #133, they acknowledged that a documented record was not kept of the complaint made by resident #009 that occurred on an identified date . [s. 101. (2) (a)]

2. The licensee has failed to ensure that the documented record of complaints received was reviewed and analyzed for trends, at least quarterly.

Review of the home's complaint binder for 2017 and 2018 failed to show that complaints were reviewed and analyzed for trends. During an interview with ED #133, they confirmed that the home had not been reviewing their complaints and analyzing for trends. [s. 101. (3) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: A description of the individuals involved in the incident, including, names of any staff members or other persons who were present at or discovered the incident.

A review of the CIS report submitted on an identified date, indicated that resident #024 was found without vital signs. The physician was called to pronounce death and completed the medical certificate. The physician called the coroner to attend as the physician noted something unusual. A review of the CIS report did not indicate the names of the staff members who discovered the incident.

Interview with clinical DOC #105 indicated that the name of the staff member who discovered the incident should have been indicated on the CIS report. [s. 107. (4) 2.]

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Issued on this 7th day of January, 2019

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

Original report signed by the inspector.