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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 6, 2019	2019_650565_0010	021783-17, 006696-18, 009866-18, 010635-18, 014253-18, 016233-18, 017230-18, 024851-18, 025964-18, 026249-18, 001992-19, 003875-19, 004531-19, 006316-19	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

MATTHEW CHIU (565), JULIEANN HING (649), JULIENNE NGONLOGA (502)

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): May 6, 7, 8, 9, 10, 13, 14,

15, 16, 17, 21, 22, and 23, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- 009866-18 for CIS report #2789-000031-18, 006316-19 for CIS report #2789-000036-19 related to falls prevention and management for resident,
- 001992-19 for CIS report #2789-000013-19, 004531-19 for CIS report #2789-000033-19 related to resident abuse, and
- 003875-19 for CIS report #2789-000026-19 related to improper transfer of resident.

During the course of the inspection, the following CIS intake logs related to falls prevention and management for resident were completed:
- 021783-17 for CIS report #2789-000072-17,
- 006696-18 for CIS report #2789-000025-18,
- 010635-18 for CIS report #2789-000037-18,
- 014253-18 for CIS report #2789-000052-18,
- 016233-18 for CIS report #2789-000059-18,
- 017230-18 for CIS report #2789-000062-18,
- 024851-18 for CIS report #2789-000077-18,
- 025964-18 for CIS report #2789-000082-18, and
- 026249-18 for CIS report #2789-000086-18.

During the course of the inspection, finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) related to resident #009, and it was issued under concurrent inspection #2019_650565_0009.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Food Services (DFS), Quality and Informatics Partner (QIP), Registered Dietitian (RD), Interim Resident Relations Coordinator (IRRC), Recreation therapist (RT), Cook, Nurse Manager (NM), Behavioural Supports Ontario Nurse (BSON), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aide (DA), Housekeeping Aide (HA), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and

procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents exhibiting altered skin integrity had been assessed by a registered dietitian who is a member of the staff of the home.

a. On an identified date, a CIS report was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to the improper care while assisting resident #006. As a result, resident #006 sustained an injury.

A review of the CIS report indicated that on the identified date, PSW #133 asked the registered staff to check the resident. Upon assessment, the specified altered skin integrity was noted.

Record review indicated resident #006 returned to the home the next day with a diagnosis of specified altered skin integrity and received treatment. Seventeen days later, the progress notes stated a specified change to their altered skin integrity.

Review of the dietitian assessment record for resident #006 did not identify a completed dietitian assessment related to the altered skin integrity mentioned above.

Interview with RN #132 indicated that when a resident has the specified altered skin integrity, the registered staff follow the skin and wound protocol and refer the resident to

the Enterostomal Therapy (ET) nurse and the RD. After reviewing the resident health record, the RN indicated a referral was not sent to the RD. RN #132 acknowledged that the RD assessment was not completed.

b. As a non-compliance was identified under O. Reg. 79/10, s. 50. (2) (b) (iii), the sample was expanded to three residents.

Review of resident #004's progress notes indicated the resident had exhibited multiple areas of specified altered skin integrity on four identified dates.

Review of the dietitian assessment record did not identify the completed nutritional assessments related to the above mentioned altered skin integrity.

In an interview, RD #131 reviewed the assessment record and indicated that no nutritional assessments were completed for the above mentioned altered skin integrity.

Interviews with RD #131 and the DOC indicated that no referrals from nursing staff related to the above mentioned altered skin integrity for resident #004 and #006 were sent to the RD, and they acknowledged that the nutritional assessments for these two residents were not completed by the RD as required. [s. 50. (2) (b) (iii)]

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 residents exhibiting the altered skin integrity are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was not neglected by the licensee or staff.

In accordance with the definition identified in O. Reg. 79/10, s. 2. (1), "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The MOHLTC received a CIS report related to an allegation of abuse that occurred on an identified date.

Review of the CIS report indicated that resident #009 was experiencing a specified health condition and asked PSW #129 for help. The report stated the interactions between PSW #129 and resident #009 who had demonstrated specified responsive behaviours. Resident #009 was neglected by PSW #129 when it was reported they were experiencing the specified health condition and the PSW #129 did not help the resident.

In an interview with PSW #129, they explained and acknowledged the above mentioned interactions with resident #009. The PSW did not report it to the nurse and stated they did not help the resident because of their responsive behaviours.

In an interview with the DOC, they acknowledged that they viewed PSW #129's action as neglect. According to the DOC, when the resident said they were experiencing the specified health condition, it was not up to the PSW to determine based on the resident's responsive behaviours. The PSW should have gotten help from the registered nurse and they did not. [s. 19. (1)]

WN #3: 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 resident #006.

On an identified date, a CIS report was submitted to the MOHLTC related to the improper care while assisting resident #006. As a result, resident #006 sustained an injury.

A review of the CIS report indicated that on the identified date, PSW #133 asked the registered staff to check the resident. Upon assessment, a specified injury was noted, and the resident was transferred to the hospital for further assessment.

Record review revealed resident #006 had multiple identified diagnoses, their cognitive skills was impaired, and required a specified number of staff and technique for transfer.

Further review of the home's records indicated that PSW #133 transferred resident #006 without the specified number of staff.

In an interview, PSW #133 stated that they were aware of the specified number of staff assistance for transferring resident #006. During the above mentioned incident, they transferred the resident without the specified transfer assistance because everyone was busy.

In an interview, the DOC acknowledged that PSW #133 had used unsafe transfer technique when transferring resident #006 on the identified date. [s. 36.]

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.