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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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_630589_0013	006816-18	Complaint

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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

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): May 13, 14, 15, 16, and 17, 2019.

The following intake was inspected during this inspection:
-log #006816-18 related to the Prevention of Abuse and Neglect, Personal Items and Aids, Continence Care and Emergency Plans.

Written Notification with a Voluntary Plan of Correction related to LTCHA, 2007, S. O. 2007, C. 8, s. 22 (1) identified in this inspection will be issued in concurrent inspection report #2019_650565_0009.

Written Notification with a Voluntary Plan of Correction related to O. Reg. 79/10, r. 101 (1) 3., identified in this inspection will be issued in concurrent inspection report #2019_650565_0009.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Dietary Services (DDS), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping Aide (HA), Complainant, and Residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions, meal service, the provision of care and housekeeping practices, reviewed health records, the home's internal investigation notes, complaints binder and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #012 and preferences of that resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint which indicated several concerns, with one of them related to food quality. A review of the complaint indicated that resident #012 often refuses to eat the food being provided.

A review of resident #012's initial assessment and the Interdisciplinary Care Conference (ICC) indicated resident #012's likes and dislikes related to nutrition. A review of resident #012's written plan of care in effect at the time of the complaint did not include the resident's likes and dislikes.

During an interview, resident #012 told Inspector #589 that if they don't like what is on the menu, they will ask for an identified food and that they usually keep a fruit from their morning meal to eat with it. Resident #012 indicated that they would not mind getting alternate options, but they were not aware of other alternatives available to them.

During an interview, staff #118 acknowledged resident #012's dislike was not included in the plan of care as they were not serving this item at the time.

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 care set out in the plan of care was based on an assessment of resident #012 and their preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

The licensee has failed to ensure that all food and fluids were prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

The MOHLTC received a complaint which indicated several concerns, with one of them related to food quality.

A review of the complaint indicated that the food being provided is "stone cold". The complainant also stated that often an identified food was not cooked thoroughly and was often pink inside, and they felt that residents were getting ill as a result.

A review of week one, of the Summer/Fall menu cycle indicated that on Day 3, the identified food item noted above was offered to the residents for lunch. On the same day after meal service, two Inspectors with staff #118 observed the left-over food item and when it was cut into pieces, it was pink inside.

A review of the standardized recipe for this food item under the preparation step, indicated that they must be cooked to an identified internal temperature, held for 15 seconds. A review of the production summary worksheet for that day did not indicate the cooking temperature. This was confirmed by staff #118. Staff #120 presented a hand written temperature record to the inspector two days later.

During an interview, staff #120 indicated that the food item was pink inside as result of a preservative that is added.

Staff #118 acknowledged that the identified food item appeared pink inside and uncooked.

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 food and fluids are prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

The MOHLTC received a complaint which indicated several areas of concerns, with one of them related to prevention of abuse and neglect. The complainant alleged that a member of the staff told resident #012 and a tablemate, to stop voicing concerns about the food. The complaint also indicated that the complainant felt the staff member should not have spoken in this manner to residents #012 and #015, and themselves.

During a conversation, resident #012 stated that the staff member had said to them that they are the only resident that voice concerns about food quality. Resident #012 felt this was inappropriate to say to them as they pay to live in the long term care home (LTCH) and that the food should be served properly cooked and at the right temperatures. Resident #012 further stated they did not feel good about how the staff member had spoken to them and that now they are careful about what they say when speaking to this staff member. During a conversation, resident #015 also recalled that the same staff member said to them they are the only residents that voice concerns about food quality.

During the inspection the staff member that allegedly spoke inappropriately to residents #012 and #015 was identified as staff #118.

During a conversation, staff #118 denied the above mentioned statement as they knew it would be inappropriate to speak to residents in this manner.

During further conversations with resident's #012 and #015, they both continued to acknowledge that staff #118 had told them to stop voicing concerns about the food quality and that they were the only residents who were.

During a conversation, staff #112 stated they were not aware that residents #012 and #015 had been spoken to inappropriately and acknowledged this was inappropriate.

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.