Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 5, 2020	2020_816722_0005	022991-19, 000099-20	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

COREY GREEN (722)

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): February 20-21, 25-26, and 28, 2020; and March 2-3, 2020.

The following intakes were inspected during this Complaint inspection:

Log #022991-19 - related to multiple care areas; and
Log #000099-20 - related to withholding a placement approval.

During the inspection, the inspector made observations of residents, resident care, staff-to-resident interactions, and resident home areas. Various records were also reviewed, including relevant home administrative records, resident health records (paper and electronic), and documentation from the Health Partnership Gateway (HPG).

During the course of the inspection, the inspector(s) spoke with the interim Executive Director (ED), Director of Care (DOC), Resident and Family Experience Coordinator (RFEC), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Local Health Integration Network (LHIN) Placement Coordinator, resident family member, and residents.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to demonstrate that the staff of the home lacked the nursing expertise necessary to meet the applicant’s care requirements.

A complaint was received by the Ministry of Long-Term Care (MLTC) from LHIN Placement Coordinator #101, related to the home withholding approval for applicant #102's admission.

Review of documentation in the Health Partnership Gateway (HPG) showed that applicant #102 was initially placed on the home's waiting list on a specified date, and was matched to a bed. The HPG notes indicated that the applicant's admission was withheld and a written notice was sent to the applicant and the LHIN.

Review of a written notice signed by interim ED #113 indicated that staff in the home lacked the nursing expertise necessary to meet the applicant's care requirements. It was noted on the letter that the applicant had several identified responsive behaviours.

Review of the applicant's pre-admission documentation (i.e., behavioural assessments, health assessments, hospital discharge notes, and medication lists) in HPG verified that the resident had specified medical diagnoses, and that the applicant had a history of various identified responsive behaviours, some of which may have posed risk to resident and staff safety in the home. The documents in HPG showed that, at the time of the bed match, the applicant was staying in a hospital while waiting for a long-term care bed.

During an interview, interim ED #113 verified that there were other residents in the home with similar medical diagnoses and responsive behaviours. They confirmed that the nursing staff had the skills and expertise to care for residents with a range of responsive behaviours, including those specified for applicant #102. They also confirmed that the home had a responsive behaviour program with an identified lead. ED #113 indicated during the interview that the home withheld admission because the management team was concerned about the safety of residents and staff in the home with the addition of another resident in the secure unit with challenging responsive behaviours.

Based on the information above, it was identified that the home's staff had the nursing expertise necessary to meet applicant #102's care requirements related to their responsive behaviours and, as such, did not meet the conditions necessary for withholding applicant #102's admission to the home. [s. 44. (7) (b)]

2. The licensee has failed to ensure, when they withheld applicant #102's approval for admission, that they provided a written notice setting out: (i) a detailed explanation of the supporting facts, as they related both to the home and to the applicant’s condition and requirements for care, and (ii) an explanation of how the supporting facts justified the decision to withhold approval.

Review of applicant #102's written notice with a specified date and signed by interim ED #113, indicated that the home did not have the necessary resources to meet the applicant's needs, and stated that "our staff lacks the nursing expertise necessary to meet your care requirements." It also noted that the applicant had a history of specified responsive behaviours. The inspector was unable to identify in the written notice a detailed explanation of the supporting facts related to the home, applicant's condition and requirements of care, or an explanation of how the supporting facts justified the decision

to withhold approval.

During an interview with interim ED #113, they confirmed that the applicant had been refused a bed in the home. The ED acknowledged that they could have provided additional information in the written notice related to the supporting facts and how they justified the decision to withhold approval. In particular, the ED pointed out that since applicant #102's admission was initially approved, new specified incidents and behaviours were documented, and the home was concerned about adding another resident with the identified behaviours into a unit that may put other residents and staff at risk.

None of the specified details described above were identified in the written notice to the applicant and LHIN placement coordinator. [s. 44. (9) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #011 was assessed using an interdisciplinary approach when they had an identified weight change of more than a specified amount over one month.

A complaint was received from resident #011's substitute decision-maker (SDM) related to various concerns with resident care related to nutrition and hydration and specified weight changes.

Resident #011's weights were reviewed in the electronic health record, which indicated that the resident's weight changed significantly (based on specified ranges in the Regulations) in a specified month. There was no documentation identified which indicated that the resident was re-weighed when the significant change was identified. A note was identified beside the documented weight which indicated that the home's Registered Dietitian (RD) struck it out as "Incorrect Documentation" nearly two months later.

Nutrition referrals and assessments were reviewed in the electronic health record. In the month with the significant weight change, there were no referrals by registered staff, and no assessments completed by the RD or physician related to the resident's weight change. A month later, an assessment was identified by the RD that noted the significant weight change on the specified date and suggested it was an error; however, a new weight was not obtained at that time. The resident was weighed almost two months after the significant change was initially identified, and it differed significantly from the previous weight.

The progress notes were reviewed and there was no mention of the initial significant weight change on the date the weight was taken, or documentation of an assessment by registered staff or the RD related to the change.

The home's Monitoring of Resident Weights policy (Policy #VII-G-20.90, Current Revision: April 2019) was reviewed and indicated that residents were to be weighed monthly by the 10th of each month, documented in the electronic health record, and that PSWs should re-weigh the resident if there was a 2 kilogram (kg) difference from the previous month. The policy also indicated that registered staff were responsible for investigating any possible reasons for weight variance, and the RD was responsible for assessing residents with identified weight variances.

PSW #124 indicated during an interview that the PSWs weighed residents at the beginning of each month and notified the registered staff of the weight. They indicated that registered staff entered the weights in the computer, compared the weight to the previous month, and would ask the PSW to re-weigh the resident if there was a "big difference".

During an interview, the RD acknowledged that the resident had a significant weight change on the identified month, compared to the weight measured in the previous month, and that the resident should have been re-weighed. The RD also acknowledged that they

did not receive a referral from the registered staff after the significant weight change, and that they did not assess the resident in the month the weight was measured. The RD indicated that they assessed the resident on a later specified date (approximately one month later), where they noted that the previous weight was a potential error; however, they acknowledged that they should have assessed resident #011 closer to the date that the significant change was identified. They also confirmed that, on another later specified date, they struck out the previous weight measurement as "Incorrect Documentation" and were unable to explain why it was struck out almost two months later.

DOC #104 confirmed during an interview that the resident had a significant change in weight on the identified date, that the resident should have been re-weighed to verify the weight, a referral sent by registered staff to the RD, and the RD should have assessed the resident. The DOC acknowledged that the resident should have been assessed by the interdisciplinary team, specifically the RD and possibly the physician, sooner than a month after a significant weight change was identified. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.