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

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
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_751649_0004	009688-19, 013671-19, 017095-19, 018942-19, 019984-19	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

JULIEANN HING (649), VERON ASH (535)

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): February 20, 21, 24, 25, 26, and 28, 2020.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Log #009688-19/ CIS #2789-000052-19 related to responsive behaviours.
Logs #013671-19/ CIS #2789-000080-19 and #018942-19/ CIS #2789-000101-19 related to falls prevention and management.
Log #017095-19/ CIS #2789-000092-19 related to plan of care and critical incidents.
Log #019984-19/ CIS #2789-000110-19 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant director of care (ADOC), registered nurses (RNs), physiotherapist (PT), registered practical nurses (RPNs), personal support workers (PSWs), and residents.

During the course of the inspection the inspectors reviewed residents' health records, staffing schedules, investigation notes, conducted observations related to the home's care processes, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident, the SDM, if any, and the designate of the resident/SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

Record review of the point click care (PCC) progress notes indicated that resident #021 had complained of feeling unwell, refused to eat meals and experienced a loss of independent mobility. Several days later, the resident's substitute decision-maker (SDM) was called by the registered staff and informed that the resident was experiencing a change in health status and was being transferred to hospital for acute assessment and treatment.

During separate interviews, RPN #106 and RN #121 verified that they did not contact the resident's SDM when the resident complained of feeling unwell.

During an interview, the home's ADOC verified that they spoke with the resident's SDM after the resident was transferred to hospital; and the SDM had expressed concerns which included the fact that they were not made aware of the resident's declining health status by the staff. The ADOC stated that the expectation was for staff to update the SDM whenever there was a change in the resident's health status to ensure participate in the plan of care.

Therefore, the home failed to ensure resident #021's SDM was provided the opportunity

to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

2. The licensee has failed to ensure resident #021 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Record review of the progress notes indicated and interviews with registered staff verified that resident #021 was admitted to acute care hospital and diagnosed with several medical conditions. The resident was treated and discharged to the home several days later. Record review of the resident's plan of care indicated that the care plan was not updated since there was no documentation that the resident was diagnosed with several medical conditions, with corresponding interventions to prevent future episodes.

During an interview, ADOC #105 reviewed the resident's care plan and stated that since the home had adapted a problem-based focus care plan, the expectation was that registered staff should update the resident's care plan to include the identified medical conditions focus with corresponding interventions to monitor and prevent future incidents.

Therefore, the home failed to ensure resident #021 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.
[s. 6. (10) (b)]

3. The licensee has failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan had not been effective.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #003's fall while ambulating.

According to the CIS report PSW #120 was holding resident #003's hand and walking next to them, when the resident suddenly had a responsive behaviour, resulting in them falling. The resident was transferred to hospital and diagnosed with an injury.

A review of the resident's plan of care at the time of the above incident indicated the use of several identified fall prevention interventions.

According to progress notes documentation the resident had refused to use the two fall prevention interventions on many occasions.

The use of two fall prevention interventions identified in the resident's current care plan was documented on the above mentioned dates, and staff interview confirmed that the resident had refused to use them.

On February 21, 2020, at approximately 1455 hours, resident #003 was observed by the inspector on the unit, without use of one of the identified fall prevention interventions. Approximately 30 minutes later the inspector returned to the unit and spoke with PSW #122 who confirmed that the resident was not using the previously mentioned fall prevention intervention.

In an interview with PSW #120, they explained the resident had refused to use the second fall prevention intervention on the day of their fall and stated that they had never seen the resident using the first fall intervention and that the resident would remove it.

In an interview with ADOC #105, they acknowledged that resident #003's plan of care should have been updated and revised when the resident had refused to use the two fall prevention interventions and moved towards another form of protection that the resident was compliant with. [s. 6. (10) (c)]

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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, the resident's care needs change or care set out in the plan is no longer necessary, and care set out in the plan has not been effective, 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 #021 was free from neglect by the licensee or staff in the home.

O. Reg. 79/10, s. 5, states that neglect means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIS report was submitted to the MLTC related to improper care of resident #021 which resulted in the resident being transferred to acute care hospital for assessment and treatment.

Record review of progress notes in PCC documentation system indicated that the resident had complained of feeling unwell, ate poorly, and experienced a decline in mobility status. The physician was contacted and ordered collection of an identified specimens.

During separate interviews, RPN #106 and RN #121 verified that they did not attempt to collect the identified specimens ordered by the physician during their shift although they could not recall the reason for not collecting the specimens. Both staff members also agreed that by not collecting the identified specimens and following up on the resident’s complaints with an intervention, their inaction fits the definition of neglect.

During separate interviews, the ADOC and DOC reviewed the progress notes during the identified period, and both verified that according to the home’s definition of neglect, the staff failed to provide the care and treatment required to support the resident’s health and well-being, including failure to collect and send the identified specimens ordered by the physician.

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, s. 19. (1). An order was issued under s. 19. (1) during inspection report #2019_780699_0025 dated February 18, 2020, with a compliance due date of March 31, 2020. A written notice (WN) has been issued under s. 19. (1) as additional evidence for the existing order not past-due. [s. 19. (1)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.