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
Jul 3, 2020	2020_797740_0013	002378-20, 002381-20, 002382-20, 002383-20, 003246-20, 004128-20, 004421-20, 007459-20, 007566-20, 008027-20, 008657-20, 009207-20, 009634-20	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

SAMANTHA PERRY (740), ALI NASSER (523)

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): June 15, 16, 17(offsite), 18,

19(offsite), 22, 23, 24 and 25, 2020

The following Critical Incident System (CIS) and Follow-up intakes were completed within this inspection:
Log# 004421-20 / CIS# 2789-000014-20 related to allegations of staff to resident abuse;
Log# 008657-20 / CIS# 2789-000027-20 also related to allegations of staff to resident abuse;
Log# 004128-20 / CIS# 2789-000012-20 related to the falls prevention and management program;
Log# 003246-20 / CIS# 2789-000010-20 related to the falls prevention and management program;
Log# 007459-20 / CIS# 2789-000022-20 related to the unexpected death of a resident;
Log# 007556-20 / CIS# 2789-000023-20 related to the unexpected death of a resident;
Log# 008027-20 / CIS# 2789-000024-20 related to the unexpected death of a resident;
Log# 009207-20 / CIS# 2789-000028-20 related to the unexpected death of a resident; and
Log# 009634-20 / CIS# 2789-000029-20 also related to the unexpected death of a resident.
Log# 002378-20 for Compliance Order #001 from inspection #2789-000014-20 related to the notification of the substitute decision maker (SDM);
Log# 002381-20 for Compliance Order #003 from inspection #2789-000014-20 related to the resident's care plan;
Log# 002382-20 for Compliance Order #004 from inspection #2789-000014-20 related to safe lifts and transfers; and
Log# 002383-20 for Compliance Order #004 from inspection #2789-000014-20 related to the home's duty to protect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the assistant Executive Director, the Director of Care, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The inspector(s) also made observations and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #005	2019_780699_0025	523
O.Reg 79/10 s. 36.	CO #004	2019_780699_0025	523
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2019_780699_0025	523

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. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the substitute decision-makers (SDMs) for resident #010 were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Compliance Order #001 for inspection # 2019_780699_0025 (A3) stated “The licensee must be compliant with r. 97. (2) of the O.Regulations.

Specifically, the licensee must:

1. Notify the resident and the resident's substitute decision-maker, if any, of the results of any investigations required under subsection 23 (1) of the Act, immediately upon the completion of the investigation and is documented.”. The compliance due date was March 31, 2020.

The home submitted a critical incident report related to allegations of staff to resident #010 verbal abuse. The SDM was informed of the allegations.

A review of resident #010's clinical records showed that the resident’s SDM was informed of the allegations of staff to resident abuse, the initiation of the investigation but there were no notes that indicated that they had been notified of the results of the investigation.

In an interview DOC #101 confirmed that the investigation was completed but the SDM was not notified of the results of the investigation.

In an interview Administrator #100 said they reviewed the investigation file and saw that the SDM was notified but did not ensure that the SDM was notified after the investigation was over.

The Administrator and DOC were informed during an interview that the Compliance Order was not complied with and will be reissued.

The licensee failed to ensure that when they became aware of an alleged incident of abuse involving resident #010 and a staff member, that the results of the investigation were communicated with the SDM upon completion of the investigation. [s. 97. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged incident of abuse of resident #009 by the licensee or staff, was immediately reported to the Director.

The home submitted a critical incident report related to alleged staff to resident physical abuse.

A review of resident #009's clinical records showed that the resident's spouse identified an injury on the resident. The resident told their spouse that a nurse caused the injury, which was reported to RPN #105 and then reported to the Nurse Manager.

In an interview RPN #105 said they were familiar with resident #009, were aware of the injury and had been informed by the resident's spouse that resident #009 said the injury was caused by a nurse. RPN #105 said that they followed the home's process and reported the allegations immediately to the nurse manager and initiated an incident report.

In an interview DOC #101 said that RPN #105 reported the allegations of staff to resident abuse to the nurse manager but the allegations were not reported to the Director immediately and should have been.

The licensee failed to ensure that the alleged incident of abuse of resident #009 was immediately reported to the Director. [s. 24. (1)]

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 with reporting certain matters to the Director when a person has reasonable grounds to suspect abuse of a resident by anyone that resulted in the harm or risk of harm to the resident, to be implemented voluntarily.

Issued on this 6th day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA PERRY (740), ALI NASSER (523)
Inspection No. / No de l'inspection :	2020_797740_0013
Log No. / No de registre :	002378-20, 002381-20, 002382-20, 002383-20, 003246-20, 004128-20, 004421-20, 007459-20, 007566-20, 008027-20, 008657-20, 009207-20, 009634-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 3, 2020
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 Midland Avenue, SCARBOROUGH, ON, M1N-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_780699_0025, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Order / Ordre :

Specifically, the licensee must:

1. Notify the resident and the resident's substitute decision-maker, if any, of the results of any investigations required under subsection 23 (1) of the Act, immediately upon the completion of the investigation and is documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the substitute decision-makers (SDMs) for resident #010 were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Compliance Order #001 for inspection # 2019_780699_0025 (A3) stated "The licensee must be compliant with r. 97. (2) of the O.Regulations.

Specifically, the licensee must:

1. Notify the resident and the resident's substitute decision-maker, if any, of the results of any investigations required under subsection 23 (1) of the Act, immediately upon the completion of the investigation and is documented.". The compliance due date was March 31, 2020.

The home submitted a critical incident report related to allegations of staff to resident #010 verbal abuse. The SDM was informed of the allegations.

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In an interview DOC #101 confirmed that the investigation was completed but the SDM was not notified of the results of the investigation.

In an interview Administrator #100 said they reviewed the investigation file and saw that the SDM was notified but did not ensure that the SDM was notified after the investigation was over.

The Administrator and DOC were informed during an interview that the Compliance Order was not complied with and will be reissued.

The licensee failed to ensure that when they became aware of an alleged incident of abuse involving resident #010 and a staff member, that the results of the investigation were communicated with the SDM upon completion of the investigation. [s. 97. (2)] (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Perry

Service Area Office /
Bureau régional de services : Toronto Service Area Office