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
Jul 3, 2020	2020_797740_0014	010242-20, 010250-20, 010407-20, 010573-20, 010574-20, 010717-20, 011340-20, 012176-20, 012320-20	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

SAMANTHA PERRY (740), AMANDA OWEN (738), JOANNE ZAHUR (589)

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): June 15, 16, 17, 18, 19, 22, 23, 24, 25, 2020.

The following intakes were completed within this Complaint inspection:
Log #010717-20 / IL-78573-TO related to care concerns and the unexpected death of a resident;
Log #010250-20 / IL-78323-TO related to infection prevention and control;
Log #010407-20 / IL-78404-TO related to infection prevention and control;
Log #010574-20 / IL-78495-TO related to infection prevention and control;
Log #010573-20 / IL-78494-TO related to care concerns and infection prevention and control;
Log #010242-20 / IL-78315-TO related to care concerns and infection prevention and control;
Log #012176-20 / IL-79350-TO related to resident care concerns;
Log #012320-20 / IL-79407-TO related to resident care concerns; and
Log #011340-20 / eCorespondence related to resident care concerns.

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

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Ministry of Long Term Care, related to resident #006's change in health status and the notification of their SDM.

Clinical records showed that when resident #006 had a change in health status on an identified date; the resident's SDM was not notified of this change.

PSW #127 stated the last time they saw resident #006 they were weak and the PSW thought the resident was unwell because they used to be independent and now, they were not.

RPN #121, RN #129, and DOC #114 stated staff were expected to inform a resident's SDM if a resident had a change in health status. DOC #114 said resident #006's SDM should have been notified about their change in health status.

The licensee failed to ensure that resident #006's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care when the resident had a change in health status. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection control program and failed to follow directive s. 174.1 (1) (3) in the LTCHA.

Section 174.1 (1) of the LTCHA, 2007, the Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it be in the public interest to do so.

Further 174.1 (3) states that every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The following is further evidence to support Compliance Order #002 from inspection #2019_780699_0024 issued on January 29, 2020, with a compliance due date of July 31, 2020, related to s. 229 (4).

1. A) COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 stated long-term care homes should immediately implement that all staff wear surgical/procedural masks at all times for source control for the duration of full shifts. This was required regardless of whether the home was in an outbreak or not. When staff were not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedural mask but must remain two meters away from other staff to prevent staff to staff transmission of COVID-19.

Furthermore, COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes, Public Health Ontario, dated April 29, 2020, stated on line 1.6 the screener wears at a minimum a mask, eye protection, and gloves or is behind a Plexiglas partition.

On a given date Inspector #738 was screened at the front entrance of the home by a staff that was not wearing eye protection or standing behind a Plexiglass partition. Another screener was present at a different table and the same was observed.

Associate ED #117 and Clinical IPAC Lead/Sienna #104 said screeners were required to wear face shields when performing their role. Associate ED #117 said they believed the instances were not reflective of the home's normal practice and they had followed up with the staff immediately about the concern.

B) On a given date, Inspector #738 observed a staff wearing their mask under their nose without maintaining two meters of physical distance, while they waited in line to be screened at the end of their shift. There were many other staff present in the room that observed this and did not say anything.

C) On a given date, Inspector #738 observed a staff walking the hallway. The staff was not wearing a mask. The inspector asked the staff if they were required to wear a mask, to which the staff replied, yes.

D) On a given date, Inspector #738 observed a staff wearing their mask under their nose. The inspector stated, I think you should be wearing a mask. The staff put their mask on, and a different staff stated they had just come back from eating.

E) On a given date, Inspector #738 observed a staff without wearing a mask. The inspector approached the staff and asked if they needed to be wearing a mask. The staff stated they had forgotten it.

F) On a given date, Inspector #738 observed a staff remove their face mask and drink something without maintaining two meters of physical distance from other staff members. A staff member of the home observed this but did not ask the staff to put their mask back on. Nor did the screeners that were also in the room. A few minutes later, the staff sat down and again, they removed their mask and drank something. The inspector brought this to the attention of Associate Executive Director #117, who said this was not acceptable. They immediately approached the staff and provided training.

G) On a given date, Inspector #738 observed a staff enter a resident's room while wearing their mask under their nose. There was droplet signage posted on the door of the room. RPN #122 stated there was only one resident occupying that room and they were positive for COVID-19.

Hospital Liaison/IPAC Lead #103, Associate ED #117, and Clinical IPAC Lead/Sienna #104 stated staff could only remove their mask when eating in the designated break

rooms.

Associate ED #117 said masks were available throughout the building. RPNs #123 and #112, and RN #111 said they had access to masks whenever they wanted, and they could easily get more if they ran out.

2. A) On a given date, Inspector #738 observed a staff exit a resident's room with dirty linens in their hands. The staff disposed the linen in a laundry cart, removed their gloves, and then went into a different resident's room. They did not perform hand hygiene prior to providing care to the next resident.

B) On a given date, Inspector #738 observed a staff exit a resident's room without performing hand hygiene and approach a resident in the hall. They spoke to the resident and touched them on the back. The staff then went back into the resident's room without performing hand hygiene. The staff member's mask was not covering their nose.

RN #119 said staff were required to wash their hands before going into the next room, even if they were wearing gloves.

Hospital Liaison/IPAC Lead #103 and Associate ED #117 said staff were required to perform hand hygiene between each resident encounter.

Clinical IPAC Lead/Sienna #104 said staff were required to perform hand hygiene whenever they touch a resident or come out of a resident's room.

3. A) On a given date, Inspector #738 observed a staff go into a resident's room without wearing a face shield. There was droplet signage posted on the door. The staff was observed speaking to resident #004 at their bedside.

RN #119 and Clinical IPAC Lead/Sienna #104 said staff were required to wear full personal protective equipment, including a face shield, when they provided care to residents with COVID-19.

4. A) COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 stated long-term care homes must immediately conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident has fever,

cough or other symptoms of COVID-19.

A review of resident #006's clinical records showed they had not been screened or assessed when their health status changed.

RPN #131 stated staff were required to screen residents for symptoms of COVID-19, including temperature checks at morning and night. They said a Daily Active Screening assessment was completed and documented in Point Click Care for residents that did not have COVID-19.

The licensee failed to ensure that staff participated in the implementation of the infection control program. [s. 229. (4)]

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.