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
Nov 2, 2020	2020_767643_0019	002379-20, 002380-20, 002384-20, 011691-20, 012663-20, 013575-20, 013907-20, 014191-20, 015541-20, 015569-20, 017400-20	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

ADAM DICKEY (643), IANA MOLOGUINA (763)

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): September 24, 25, 28, 29, 30, October 1, 2, 5, 6 and 7, 2020. Additional off-site inspection activities were conducted on October 8, 2020.

The following complaint intakes were inspected during this inspection:
Log #011691-20 - related to personal support services;
Log #012663-20 - related to prevention of abuse and responsive behaviours;
Log #013907-20 - related to skin and wound care;
Log #014191-20 - related to infection control and hot weather protocols;
Log #015541-20 - related to skin and wound care and prevention of abuse; and
Log #017400-20 - related to infection prevention and control.

The following critical incident system (CIS) intake was inspected during this inspection:
Log #015569-20, CIS #2789-000034-20 - related to prevention of abuse.

The following Compliance Order (CO) follow-up intakes were inspected during this inspection:
Log #002379-20 - related to skin and wound care;
Log #002380-20 - related to compliance with the home's abuse policy;
Log #002384-20 - related to infection prevention and control; and
Log #013575-20 - related to abuse investigation reporting.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Associate Executive Director, the Director of Care (DOC), Associate Directors of Care, Director of Environmental Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian, Behavioural Supports Ontario (BSO) RPN, Resident and Family Experience Coordinator, Personal Support Workers (PSW), Ward Clerk, residents and family members.

During the course of the inspection the inspector(s) conducted observations of medication administration, resident and staff interactions and the provision of care, reviewed resident health records, staff training materials and records, the home's incident investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- 4 WN(s)
- 2 VPC(s)
- 0 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. 20. (1)	CO #002	2019_780699_0025	643
O.Reg 79/10 s. 229. (4)	CO #002	2019_780699_0024	643
O.Reg 79/10 s. 50. (2)	CO #001	2019_780699_0024	643
O.Reg 79/10 s. 97. (2)	CO #001	2020_797740_0013	643

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident was provided a scheduled treatment as set out in the resident's plan of care.

The resident had an ongoing area of altered skin integrity with a scheduled treatment to be carried out three times per week. The treatment administration record (TAR) showed "see nurse notes" for one of the scheduled treatments, with the progress note indicating the RN was unable to complete the treatment due to the computer being down. The RN indicated there were issues with the computer system and had not consulted the resident's physical chart for the treatment order. The treatment was not communicated to or completed by RPNs #124 and #125 who worked on the following shift. The resident was at risk of actual harm as the treatment was required to promote healing and prevent infection in the ongoing area of altered skin integrity.

Sources: Resident skin and wound assessments, physician's order sheets, TAR, progress notes, interviews with registered staff. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident’s plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to identify the use of a restraint by a physical device for residents #005 and #012 in the residents' plan of care.

a. Inspector #763 observed resident #005 in a position that was potentially restraining while resting in their room on two occasions. The resident was incapable of rising from the potentially restraining position without staff assistance. The resident’s direct care staff indicated they often placed the resident in potentially restraining position because the resident was at risk of falling. The unit RN confirmed that this form of a restraint for the resident was not included in the resident's plan of care. The RN indicated that staff were expected to use other interventions to manage the resident's fall risk, such as a chair alarm, to limit the need for a restraint.

Sources: observations, resident #005’s plan of care, staff interviews (RN #117, PSW #126, ADOC #109).

b. Inspector #763 observed resident #012 in a position that was potentially restraining while resting. The resident was incapable of rising from the potentially restraining position without staff assistance. The resident’s direct care staff indicated they frequently placed the resident in potentially restraining position because they were at risk of falling. The unit RN confirmed that this form of a restraint for the resident was not included in the resident's plan of care. The RN indicated that staff were expected to use other interventions to manage the resident's fall risk, such as a chair alarm, to limit the need for a restraint.

The home’s restraint program lead indicated staff should have notified the management team prior placing residents #005 and #012 in a potentially restraining position, so that an interdisciplinary assessment of the restraint use could be conducted.

Sources: observations, resident #012’s plan of care, staff interviews (PSW #129, RPN #121, ADOC #109). [s. 31. (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 ensuring that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided annual training on minimizing the restraining of residents.

As a result of non-compliance found with s. 31. (1) during this inspection, the home's annual education records for minimizing restraint use were reviewed. It was determined that 11 per cent of nursing department staff had not completed the training for 2019, with 17 staff marked as incomplete. Four of the 17 staff were still actively working in the facility.

Sources: The home's training records, ADOC #109. [s. 76. (7) 4.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #002 from Inspection #2019_780699_0025 served on January 29, 2020, amended on April 22, 2020, with a compliance due date of July 31, 2020.

The licensee failed to complete step 2. (a) of the order, as the tool to be utilized for any alleged or suspected abuse/ neglect investigation was not readily accessible at all nursing stations. The inspector approached registered staff members on the second, third and fourth floors of the home. The registered staff were unable to locate the above mentioned tool at any of the three above nursing stations. ADOC #109 attended the three nursing stations with the inspector and did not locate the above tool as ordered in CO #002.

Sources: CO #002 from #2019_780699_0025, Inspector observations, interviews with ADOC #109 and registered staff and the home's compliance plan. [s. 101. (3)]

Issued on this 5th day of November, 2020

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

Original report signed by the inspector.