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
Oct 13, 2021	2021_650565_0014	010061-21, 010062-21, 011676-21, 012591-21, 014562-21	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

MATTHEW CHIU (565), APRIL CHAN (704759)

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 15-16, 20-21, 23 -24, 27-29, October 1, and 4-6, 2021.

The following intakes were completed in this complaint inspection:
- Log #010061-21 was related to follow up to Compliance Order (CO) #001;
- Log #010062-21 was related to follow up to CO #002; and
- Log #011676-21, Log #012591-21, and Log #014562-21 were related to multiple care concerns and prevention of abuse and neglect for residents.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director Environmental Services (DES), Infection Prevention And Control Lead (IPACL), Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff (HS), Residents and Family Members.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
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. 6. (7)	CO #001	2021_876606_0011	565
O.Reg 79/10 s. 8. (1)	CO #002	2021_876606_0011	565

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 a 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.

Staff noticed a change in the resident's condition, and the resident was examined by a physician on the same shift. The physician ordered an examination for the resident to rule out a medical condition. The requisition for the examination was sent out on the next shift.

A few days later, the resident was transferred to the hospital due to a decline in their condition. The resident's SDM was not notified of the earlier change in condition or the order of the examination until after the hospital transfer. Staff indicated when the examination was ordered, the SDM of the resident should have been notified, but they were not.

The DOC acknowledged that the resident's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care related to the order of the examination.

Sources: The resident's progress notes and physician orders; interviews with the resident's SDM, the RPN, RN, and the DOC. [s. 6. (5)]

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received oral care, to maintain the integrity of the oral tissue, that included the physical assistance to brush their own teeth.

The resident required assistance from staff to brush their teeth and for oral care. Staff interviews and the resident's plan of care indicated the oral care should be provided to the resident every morning, evening and after each meal.

An observation was conducted during lunch and until approximately one hour after the resident's lunch. No oral care, including brushing the resident's teeth, was provided to the resident as required.

The resident's primary PSW indicated that they provided oral care to the resident during the morning care without brushing the resident's teeth. The staff admitted no oral care, including brushing the resident's teeth, was provided to the resident after their lunch.

An RPN stated the resident's SDM wanted the resident's teeth to be brushed in the morning, evening and after each meal. The ADOC acknowledged that the resident was not provided with the assistance to brush their teeth as required.

Source: The resident's care plan and progress notes; observation; and interviews with the PSW, RPN, ADOC, and other staff. [s. 34. (1) (b)]

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 each resident of the home receives oral care to maintain the integrity of the oral tissue that includes physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperatures were documented in writing, at a minimum in the following areas of the home:
- One resident common area on the ground floor; and
- Every designated cooling areas on the ground floor.

The home documented all air temperature monitoring on an air temperature log form. Upon review of these records, dated between August 1 and September 15, 2021, the air temperatures for at least one ground floor common area were not documented as required by legislation.

Residents were observed accessing the main lobby of the ground floor. Staff interviews verified that the residents have access to the ground floor, including main lobby and library.

The DES verified that the ground floor is a common area and they confirmed staff currently do not record air temperatures of the ground floor.

Sources: Air temperature log forms; observations on the ground floor; and interviews with the ED and DES. [s. 21. (2) 2.]

2. Further review of the air temperature log forms dated between August 1 and September 15, 2021, the air temperatures for the ground floor designated cooling areas of the dining hall and library were not documented as required by legislation.

The DES stated that the ground floor had a designated cooling area located in the dining room. The ED verified that the ground floor dining room and the library were designated cooling areas. They confirmed that staff did not record air temperatures of the designated cooling areas of the ground floor.

Sources: Air temperature log forms; observations on the ground floor; and interviews with the ED and DES. [s. 21. (2) 3.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
- Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Staff reported that a resident had developed a sign and symptom and they were seen by a physician on the next day. The physician ordered an examination and the result came back after a few days that the resident had a significant injury. The resident was taken to the hospital and found another significant injury.

Review of CIS records and interviews with staff confirmed that the home had not informed the Director and submitted the CIS report related to the above-mentioned incident.

Sources: CIS report records; the resident's progress notes; and interviews with the RPN and DOC. [s. 107. (3)]

Issued on this 14th day of October, 2021

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

Original report signed by the inspector.