Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: November 23, 2022

Inspection Number: 2022-1280-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Midland Gardens Care Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Wing-Yee Sun (708239)	Wing Yee Sun 2022.12.06 09:27:03 -05'00'

Additional Inspector(s)
Kim Lee (741072)
Christine Francis (740880)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 1-4, 7-10, 14 and 15, 2022

The following intake was inspected in this complaint inspection:
Intake #00008213 was related to falls prevention and management.

The following intakes were inspected in this Critical Incident Systems (CIS) inspection:
Intake #00001530 was related to alleged physical abuse;
Intake #00005045 was related to injury with unknown etiology;
Intake #00005983 was related to transferring technique; and
Intake #00008326 was related to falls prevention and management.

The following intakes were completed in the Critical Incident System Inspection:
Intake #00002369,
Intake #00002654,
Intake #00002667,
Intake #00002888,

Intake #00004132,
Intake #00005081,
Intake #00005880, and
Intake #00006326 were related to falls prevention and management;
and Intake #00005065 was related to an injury with unknown etiology.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee failed to ensure that there was a hand hygiene program in place in accordance with a standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

One bottle of expired ABHR was found outside a resident room that was on Additional Precautions and another on an Activity Department cart located inside the nursing station on a resident home area.

A Registered Practical Nurse (RPN) acknowledged that the expiry date on the ABHR was not clear since it was in the French language but thought it was expired. They acknowledged the ABHR should not be used and there was a risk that the expired product would not be as effective against infections. They removed both bottles of ABHR immediately and replaced them with new bottles.

An Associate Director of Care (ADOC) acknowledged that the ABHR were expired and on the same day had checked the home for other expired ABHR. The IPAC Lead completed an audit for expired ABHR and acknowledged they would complete audits for expired ABHR on an ongoing basis.

Sources: Observations on an identified date, and interviews with a RPN and other staff.

[708239]

Date Remedy Implemented: November 8, 2022

WRITTEN NOTIFICATION: Skin and Wound Care

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (i)

The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

In an email communication from a Registered Nurse (RN) to the Director of Care (DOC), it was identified that a resident had been identified with an area of altered skin integrity after personal care.

During an interview with the RN, it was acknowledged that the resident had altered skin integrity, however a skin assessment was not completed. The RN and DOC both acknowledged that a skin and wound assessment should have been completed and documented.

The licensee's policy titled "Skin & Wound Care Management Protocol – Skin & Wound App, VII-G-10.92" directed nursing staff to complete an electronic skin and wound assessment for residents exhibiting altered skin integrity, along with weekly assessments until the skin alteration is healed.

There was a potential risk of delaying treatment and interventions required to promote healing when the resident's skin alteration was not assessed.

Sources: Interviews with the RN and DOC, email communication from the RN to DOC on an identified date, and licensee's policy titled "Skin & Wound Care Management Protocol – Skin & Wound App, VII-G-10.92" last revised November 2021.

[740880]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard issued by the Director with respect to IPAC was implemented.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard). Specifically, the licensee failed to ensure that Routine Practices were followed related to hand hygiene, including, but not limited to, the four moments of hand hygiene, as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

A Personal Support Worker (PSW) was observed assisting residents in the dining room during the lunch meal on a specified home area. The PSW was seen removing soiled dishes from a resident, then proceeded to assist a different resident with their meal. The PSW did not perform hand hygiene between resident interactions.

The PSW, a RPN, and the IPAC Lead, all acknowledged that staff were required to perform hand hygiene after handling soiled dishes and prior to performing other activities.

The licensee's policy titled "Hand Hygiene, IX-G-10.10" directed staff to perform hand hygiene according to the four moments of hand hygiene, including after resident environment contact.

Due to the failure to ensure that hand hygiene was performed according to Routine Practices, there was a risk of infectious disease transmission.

Sources: Observation on an identified date, interviews with a PSW, RPN, and IPAC Lead, and licensee's policy titled "Hand Hygiene, IX-G-10.10" last revised December 2021.

[740880]

WRITTEN NOTIFICATION: Plan of Care

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to one resident.

Rationale and Summary

The resident sustained an injury on an identified date, which required further intervention in hospital.

A RPN acknowledged that based on their assessment, the resident would have benefited from being transferred to the hospital. Based on the wording of the resident's code status, the RPN felt they required consent from the Power of Attorney (POA) to send the resident to the hospital. They were unable to reach the POA or other family members. Three other RPNs worked on the day of the incident and acknowledged that the wording of the resident's code status did not provide clear direction to staff. One of the RPNs spoke with the POA after the resident was transferred to the hospital and the code status was updated.

The DOC acknowledged that the resident's transfer to hospital was delayed due to confusion with the wording of the code status. The DOC acknowledged that the code status was not meant for acute injuries and the RPN misinterpreted the direction.

Sources: Critical Incident System report for the incident, the resident's code status, home's investigation notes, and interviews with the RPN, DOC and other staff.

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WRITTEN NOTIFICATION: Duty to Protect

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was free from neglect by the licensee or staff in the home.

Section 7 of the Ontario Regulations 246/22 defines neglect as the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

On the night shift of an identified date, a PSW failed to conduct hourly safety checks for the resident from approximately 2300 and 0330 hours. The resident was found in bed, with an injury. Staff suspected the resident had a fall in their room. As a result of the incident, the resident sustained an injury and required further interventions in the hospital.

A RPN acknowledged that the resident was still bleeding but could not tell where the bleeding was coming from due to the injury. They felt the resident required to be transferred to the hospital after their initial assessment. Typically, with injuries to the identified area of the body they would have sent the resident to the hospital. They were confused by the code status for the resident, and failed to call the doctor or manager on call for further direction. They documented that the doctor onsite during the day shift could assess the resident.

When another RPN came on duty during the day shift and assessed the resident, they determined that the resident required immediate medical attention based on the location of the injury. The ambulance was called immediately, and the doctor was consulted. The doctor determined the resident required urgent imaging and medical attention.

The DOC acknowledged that the resident was neglected by staff who did not complete safety checks. The DOC acknowledged that they expected the resident to have been sent to hospital immediately and expected to have been informed sooner about this incident.

Sources: Critical Incident System report for the incident, home's investigation notes, the resident's clinical files, and interviews with the RPNs, DOC and other staff.

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