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

Toronto District
5700 Yonge Street, 5th Floor
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Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 21, 2023	
Inspection Number: 2023-1280-0005	
Inspection Type: Follow up 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 Cindy Ma (000711)	**Inspector Digital Signature** Shuang Yu Ma
Additional Inspector(s) Fiona Wong (740849)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 10-11, 14-16, 2023.

The following intake(s) were inspected:

- Intake: #00089452 - [CI: 2789-000019-23] – Fall with injury
- Intake: #00090021 - Follow-up related to staff to resident abuse
- Intake: #00092040 - [CI: 2789-000024-23] – Improper care of resident resulting in injury

The following intake was completed in the CIS inspection:

- Intake: #00088671 [CI: 2789-000015-23] - related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1280-0003 related to FLTCA, 2021, s. 24 (1) inspected by Fiona Wong (740849)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

A resident was assessed to be at risk for falls, and was recommended a falls prevention intervention that was unclear in their plan of care.

Three Personal Support Workers (PSWs) stated their interpretation of the above-mentioned falls prevention intervention was not consistent.

A Registered Practical Nurse (RPN), Physiotherapist (PT) and an Associate Director of Care (ADOC) indicated that the above-mentioned falls prevention intervention was not clear.

Failure to set out clear directions in the resident's written plan of care increased the risk of providing inconsistent care to mitigate falls.

Sources: Interviews with PSWs, an RPN, a PT, and an ADOC, the resident's care plan.
[740849]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident's care plan indicated that they required a certain level of assistance for their activities of daily living (ADL).

During the morning care provided by a PSW on a specified day in July 2023, the resident had a fall that resulted in an injury.

The PSW and an ADOC confirmed that assistance was not provided as indicated in their plan of care.

There was risk and harm to the resident when the care plan direction was not followed by a staff, as the resident sustained a fall and injury.

Sources: Resident's care plan; and interviews with a PSW and an ADOC.
[000711]

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to comply with pain management processes for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that there is a pain management program that provides for strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices, and assistive aids.

Specifically, staff did not comply with the policy "Pain and Symptom Management", which was included in the licensee's Pain Management Program.

Rationale and Summary

An RPN conducted a pain assessment after a resident sustained a fall. Pain was identified during the assessment.

The home's pain and symptom management policy directs staff to implement pharmacological and/or non-pharmacological interventions when resident reports or exhibits signs and symptoms of pain.

The RPN confirmed that pain management intervention was not implemented when pain was identified for the resident, and it should have been implemented.

Failure to implement pain management interventions when pain was identified increased the risk of the resident experiencing unmanaged pain for a longer period.

Sources: Interviews with an RPN, the resident's clinical records, the home's pain and symptom management policy.
[740849]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.

The licensee has failed to comply with a responsive behaviour protocol for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that protocols for the referrals of residents to specialized resources were developed to meet the needs of residents with responsive behaviours.

Specifically, staff did not comply with the policy "Responsive Behaviour Management".

Rationale and Summary

A resident was assessed to be at risk for falls. They required a certain level of assistance when transferring in and out of bed.

On a day in May 2023, the resident sustained a fall. Within a given date range in June 2023, multiple documentation indicated that the resident exhibited a new responsive behaviour that increased their risk of falls. On a specified date in June 2023, the resident sustained another fall causing injury. Over a number of months prior to the above-mentioned timeframe, there were no documentation regarding this behaviour.

A PSW stated that this behaviour was unusual during that time and required staff to conduct more frequent checks on the resident. A RPN also indicated that direction was provided to staff for closer monitoring due to resident's new behaviour.

The home’s responsive behaviour management policy directs nurses to complete an electronic responsive behaviour referral to the internal behavioural support lead/designate when there is a new, worsening, or change in responsive behaviour.

The Behavioural Support Ontario (BSO) Nurse indicated that the above-mentioned responsive behaviour was new, but they were not aware of it until a BSO referral was sent after the second mentioned fall. The RPN and the BSO confirmed that a referral should have been sent when the resident exhibited the new behaviour.

Failure to promptly refer the resident to BSO delayed the process of managing their new responsive behaviour.

Sources: Interviews with PSW and other staff, the resident’s clinical records, and the home’s responsive behaviour policy.
[740849]

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