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
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 19, 2024

Inspection Number: 2024-1280-0001

Inspection Type:
Complaint
Critical Incident

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

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

Lead Inspector	**Inspector Digital Signature**
Cindy Ma (000711)	Shuang Yu Ma Digitally signed by Shuang Yu Ma Date: 2024.05.08 14:33:45 -04'00'

Additional Inspector(s)
Matthew Chiu (565)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18-22, 25-28, 2024 and April 2-4, 2024

The inspection occurred offsite on the following date(s): April 5, 9, 2024

The following intake(s) were inspected:

- Intake: #00108698 [Critical Incident (CI): 2789-000006-24] was related to infection prevention and control
- Intake: #00105675 - [CI: 2789-000003-24] was related to fall with inquiry
- Intake: #00107671- [CI: 2789-000004-24] was related to improper care
- Intake: #00109737 [CI: 2789-000007-24] was related to staff to resident abuse

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The following intake(s) were inspected in this Complaint inspection:

- Intake: #00107937- was related to foot and nail care; turning and repositioning; pain management; medication management; palliative care; nutritional care; infection prevention and control; and dealing with complaints
- Intake: #00110648- was related to registered staffing

The following intake(s) were completed:

- Intake: #00104163 - [CI: 2789-000039-23]; Intake: #00105366 - [CI: 2789-000042-23]; Intake: #00105367 - [CI: 2789-000043-23]; Intake: #00107877 - [CI: 2789-000005-24] – were related to infection prevention and control

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and personal support services

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (d)
Nursing and personal support services
s. 35 (3) The staffing plan must,

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 11 (3) of the Act, cannot come to work; and

The licensee has failed to comply with their written staffing back-up plan.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that there was a written staffing plan including a back-up plan for their organized programs of nursing services and personal support services that addresses situations when staff could not come to work and must be complied with.

Specifically, staff did not comply with the written staffing back-up plan titled "Staffing Contingency Plan Template", that when there was one vacant Registered Practical Nurse (RPN) on night shift, the plan included replacing the vacant RPN with an agency staff or have additional Personal Support Worker (PSW) staff called in to support.

Rationale and Summary:
During a night shift, the home had one Registered Nurse (RN) and two RPNs scheduled on duty. In the evening, one of the RPNs called in unable to report for duty. Staff interviews and record review revealed that the home attempted to find a replacement from their available registered staff, but were unsuccessful. Additionally, they did not explore the agency option or call additional PSW staff for support. The remaining registered staff were asked to redistribute their responsibilities to cover the vacant RPN's duties. The Executive Director (ED) confirmed that their staffing back-up plan required staff to explore agency support, and staff were expected to notify the ED to proceed with agency replacement. However, this protocol was not followed.
The non-compliance posed a risk of compromised care and safety for residents.

Sources: Home's staffing records, staffing contingency plan template; interviews with an RN and other staff.
[565]

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)
Plan of care
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.

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 related to meal texture.

Rationale and Summary
A resident's written plan of care indicated they were on a modified texture diet.

Progress note indicated that the resident was provided with a type of food that was of different texture.

Progress notes review and interview with the Registered Dietitian (RD) indicated that staff had trialed the resident on a different textured food. The RD stated that staff were not supposed to alter the resident's diet without their knowledge.

The RD confirmed that when staff provided a different textured food to the resident it was not according to the resident's plan of care.

Failing to follow the plan of care related to meal texture put the resident at risk for potential harm.

Sources: Resident's clinical notes; and interview with an RD.
[000711]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that two residents were reassessed and their plan of care reviewed and revised when the resident's footcare needs changed.

Rationale and Summary
(i) A complaint regarding a resident's toenails was brought to the attention of the home in 2024. The resident had been receiving external footcare services, which included cutting of toenails. However, the resident's last footcare service was recorded in 2023. Staff interviews revealed that they were unaware that the resident's footcare services had stopped after this. One PSW mentioned having cut the resident's toenails during shower sessions but were unable to recall specific dates during the interview, and no documentation of footcare provision by the staff was found. Another PSW who provided care to the resident during the same period stated that footcare provided to the resident had never involved cutting the

resident's toenails. Since the discontinuation of external footcare services in 2023, staff interviews and record review confirmed that the resident's footcare needs had changed and the resident was not reassessed and their plan of care was not revised for their footcare.

The non-compliance posed a risk of unclear direction for the resident's footcare.

Sources: Home's investigation records; resident's care plan, support actions, documentation survey report v2, progress notes; interviews with PSWs and other staff.
[565]

Rationale and Summary
(ii) A resident had been receiving external footcare services, which included cutting of toenails.

Record review indicated that the resident last received foot care services in 2023.

In 2024, progress note indicated that the resident's toenails needed trimming. An RPN also confirmed that resident's toenails required trimming.

An ADOC indicated that the resident's foot care service from the external footcare was stopped after a specified date in 2023. Since the discontinuation of external footcare services in 2023, record review confirmed that the resident's foot care needs had changed, and the resident was not reassessed and their plan of care was not revised for their foot care needs.

The ADOC acknowledged that the resident's care needs changed when external foot care service was discontinued, and their plan of care related to foot care needs,

required reassessment.

Failing to ensure that the resident's plan of care was reassessed and revised posed a risk of unclear directions for the resident's footcare.

Sources: Resident's clinical records; pictures of resident's toenails; and interviews with an RPN and ADOC.
[000711]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint that they received concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary
A written complaint concerning the care of a resident was sent to the home on a specified date in 2024. Staff interview and record review revealed that the DOC received and acknowledged the receipt of the complaint the following day. However, the written complaint was not forwarded to the Director immediately, but

until one day later.

The non-compliance posed a risk for delay in addressing concerns for the care of the resident, potentially leading to further harm or negative outcomes.

Sources: Home's investigation and complaint records, CIS #2789-000004-24; interview with the DOC.
[565]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the suspicion of abuse of a resident was reported to the Director immediately.

Rationale and Summary
A resident reported to a PSW that another PSW hit them. Upon receipt of this information the PSW reported it to the RPN on duty, who then spoke with the resident. The RPN did not report the incident, claiming that the resident did not remember. The following day, the resident was observed with an injury and stated that they were hit by someone.

Record review and staff interviews confirmed that the suspicion of abuse of the resident was not reported immediately.

Sources: CIS #2789-000007-24, resident's progress notes; interviews with a PSW and other staff.
[565]

WRITTEN NOTIFICATION: Foot care and nail care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee has failed to ensure that a resident received fingernail care, including cutting of fingernails.

Rationale and Summary
A resident had been receiving fingernail care, including cutting of fingernails from the home.

An RPN acknowledged that the resident's fingernails needed to be cut. Record review indicated that the in-house physician assessed the resident and noted the need for resident's fingernails to be cut and shaved.

The RPN acknowledged that they should have cut the resident's fingernails properly.

Failing to ensure that the resident received proper fingernail care put the resident at risk for potential infection.

Sources: Resident's clinical records; pictures of resident's fingernails; and interview with an RPN.
[000711]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff participated in the implementation of the home's infection prevention and control (IPAC) program related to Personal Protective Equipment (PPE).

Rationale and Summary
A PSW was observed doffing their PPE in the following order: taking off the gown first and then gloves, after they had provided care to a resident who was on precautions.

The home's policy directed staff to remove protective equipment in the following order: gloves, gown, perform hand hygiene, protective eyewear, mask/N95 respirator, and hand hygiene.

The PSW acknowledged that they did not doff PPE in the appropriate order upon exiting the resident's room.

Infection Prevention and Control (IPAC) Lead acknowledged that the PSW did not doff PPE in the appropriate order upon exiting the resident's room.

Staff not doffing their PPEs according to the routine practices and in the appropriate order increased the risk of spreading infectious disease amongst residents, staff, and others.

Sources: Inspector's observation, home's personal protective equipment policy, and interviews with a PSW and the IPAC Lead.
[000711]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee has failed to ensure that a documented record was kept in the home

that included every date on which any response was provided to a resident's substitute decision maker (SDM) regarding their verbal complaint and a description of the response.

Rationale and summary
Record review and staff interviews confirmed that a resident's SDM raised concerns about the care of the resident's toenail and fingernail.

Email record by an ADOC indicated that the home told the resident's SDM that they would conduct further fact finding.

A review of the home's 2024 complaint logs and record reviews did not include record of any response provided to the resident's SDM regarding the outcome of home's investigation and a description of the response. A Resident Family Experience Coordinator (RFEC) and ADOC both confirmed that no response was provided to the resident's SDM. They acknowledged that a documented record with a response should have been provided to the resident's SDM.

The non-compliance posed a risk for delay in addressing concerns for the care of the resident.

Sources: Home's 2024 complaints logs; home's email communications; and interviews with an RFEC and ADOC.
[000711]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Respiratory Syncytial Virus outbreak was declared by the Public Health Unit (PHU) on a home area. A Critical Incident System (CIS) report was not submitted immediately to the Director.

The IPAC Lead and ADOC both acknowledged that the outbreak was not reported to the Director immediately, as required.

There was a minimal risk associated with the delayed reporting, as interventions were promptly implemented.

Sources: Review of CIS #2789-000006-24; interviews with IPAC Lead and ADOC. [000711]