Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2017	2017_632502_0022	027792-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 8, 11, 12, 13, 14 and 15, 2017.

The following critical incident report (CIS) was inspected during this inspection: log #027792-17 related to an identified incident by resident #002.

The following evidences related to s. 19. (1), s. 6. (4) (b), and s. 6 (7) will be captured under inspection report 2017_324535_0023.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical nurse (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Nurse Managers (NM), Residents, Manager of Tender Loving Care (TLC) Nursing Agency, Manager of Precision Security, and Security Guard.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of staff to resident interactions and the provision of care, record review of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs, is fully respected and promoted.

On an identified date and time, the inspector observed resident #001 lying on the floor, his/her continence care product was partially opened, uncovered, and the bedroom door was wide open. The resident was observed attempting to close the tape of the continence care product.

Observations of the surrounding area revealed that resident #001's bedroom door open to a common area, and other residents were observed sitting in the common area looking into the resident room.

Review of the most recent Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessment, revealed that resident #001 was cognitively intact, consistent and a reasonable decision-maker and had specified medical condition.

Review of the progress notes revealed that on identified date and time, resident #001 had a fall and was found on the floor at his/her bedside leaning on the left side of his/her body.

During an interview, staff #122 acknowledged that the door was open while resident #001 was lying on the floor uncovered. He/she stated that the staff were confused as they were calling for assistance to transfer resident #001 back to bed after the fall, and that they did not pay attention to the door or the fact that resident was exposed to the public and not covered.

During an interview, staff #118 stated that when he/she was called that resident #001 was on the floor, he/she ran into the resident room and forgot that the door was wide open. Staff #118 acknowledge that he/she should have close the door or cover the resident while waiting for the lift and assistance from other staff.

During an interview, staff #101 acknowledged that resident #001's right to be afforded privacy in caring for his or her personal needs was not respected, as he/she was left uncovered and the door wide open while being transferred back to bed. [s. 3. (1) 8.]

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 19th day of December, 2017

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

Original report signed by the inspector.