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

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| **Report Issue Date:** June 13, 2023 | |
| **Inspection Number:** 2023-1280-0003 | |
| **Inspection Type:**<br>Complaint<br>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**<br>Fiona Wong (740849) | **Inspector Digital Signature**<br>Fiona Hoi Kwan Wong-Dip<br>Digitally signed by Fiona Hoi Kwan Wong-Dip<br>Date: 2023.06.15 10:50:03 -04'00' |
| **Additional Inspector(s)**<br>Ann McGregor (000704) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 4-5, 8-11, 15, 2023.

The following intake(s) were inspected:
- Intake: #00021412 - CIS #2789-000004-23 - related to falls prevention and management.
- Intake: #00083949 - complaint related to safe and secure home.
- Intake: #00084222 - CIS #2789-000006-23 - related to staff to resident abuse.

The following intake(s) were completed:
- Intake: #00085197 - CIS #2789-000008-23 - related to falls prevention and management.

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
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 were clear directions provided for staff and others in the plan of care for a resident.

**Rationale and Summary**
The resident was assessed to be at risk for falls.

On a specified day, the resident had a fall. At the time of the fall, a Registered Practice Nurse (RPN) and a Personal Support Worker (PSW) that attended to the resident were unaware that the resident was at risk for falls. The home's investigative notes and interviews with the RPN, a Registered Nurse (RN) and two PSWs confirmed that the staff was not aware of a specified falls prevention intervention to ensure safety of the resident.

The Critical Incident Report (CIS) stated that staff failed to implement the specified falls prevention intervention to ensure resident safety as per their care plan. However, there were no documentation in the resident's plan of care or Kardex that instructed staff to implement that specified intervention. Interviews with staff further validated that the specified intervention was not clearly written in their plan of care. Interviews with the Assistance Director of Care (ADOC), the Falls Lead and the Physiotherapist confirmed that the specified intervention was not written clearly in the resident's plan of care and that more education was needed.

There were moderate impact and risk to the resident, as they might have an increased risk for falls when they were unclear directions in the plan of care.

**Sources**: Interviews with an RPN, an RN, and two PSWs. Interview with the ADOC and the Falls Lead. The home's falls prevention and management policy, The homes' Investigative notes, The home's resident safety rounds policy.

[000704]

## WRITTEN NOTIFICATION: Plan of Care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to reassess and revised the plan of care for a resident when the care set out in the care plan was not effective.

**Rationale and Summary**
The resident was assessed to be at risk for falls. After the first fall on a specified date, the team kept the fall prevention interventions that were developed prior to the fall and did not modify them after the fall.

The falls prevention strategies that were created on a specified date did not include any new or additional interventions to prevent future falls for the resident. According to a registered staff, the home has a specified falls prevention equipment but they were never trialed with the resident.

There were moderate and risk to the resident as a result of the home not reassessing and revising the plan of care to include another falls prevention equipment for the resident.

**Sources**: Interviews with an RPN, an RN, and two PSWs. Interview with the ADOC and the Falls Lead. The home's falls prevention and management policy, The homes' Investigative notes, The home's resident safety rounds policy, the resident's clinical records.

[000704]

## WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with their written policy to promote zero tolerance of abuse and neglect of residents.

**Rationale and Summary**
On a specified date, a PSW witnessed staff to resident abuse. The PSW emailed their observations to the Team Member Coordinator (TMC), however the TMC was out of office. The home was not aware of the abuse until much later when the TMC returned to work.

The home's prevention of abuse and neglect policy states that if any team member suspects an incident of abuse of a resident by anyone, that team member is responsible to immediately inform the nurse in charge in the community.

The Director of Care (DOC) stated that the PSW should have immediately reported to the charge nurse when resident abuse was witnessed.

There was risk for further resident abuse when the incident was not immediately reported.

**Sources**: interviews with a PSW and the DOC, The home's prevention of abuse and neglect policy.

[740849]

## WRITTEN NOTIFICATION: Emergency Plans

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 90 (1) (a)

The licensee has failed to comply with their emergency plan.

In accordance with O. Reg. 246.22, s. 11 (1) (b), the licensee was required to ensure that an emergency plan was in place for the home that comply with the regulations, including measures for dealing with responding to and preparing for emergencies.

Specifically, staff did not comply with their policy "Code Grey: Infrastructure Loss/Failure (loss of one or more essential services/internal flood), dated. July 2022, which was included in the licensee's Care Community Emergency Plan.

**Rationale and Summary**
On a specified date, the magnetic locks on exit doors leading to stairs were not working. The doors could be opened without unlocking with a keypad or a release button. This was observed on the first floor, second floor, and the fourth floor. The fourth floor was a secured unit.

The home's Code Grey policy states that team members would be assigned to monitor exit doors until the problem is resolved. The DOC stated that extra staff were scheduled to ensure that the exit doors were guarded. The expectation was that the staff would sit near the doors.

No staff was seen sitting near the north or south exit doors on the second floor nor the north exit doors on the fourth floor.

An RN stated that the expectation was for staff caring for residents residing near the exit doors to routinely check the exit doors for resident's safety. The DOC confirmed that this was an inappropriate way of guarding the exit doors when the magnetic locks were not working.

Failure to follow the home's emergency plan when the door access control system was not working increased resident's safety risk during an emergency.

**Sources**: Inspector's observations, the home's policy on Code Grey: Infrastructure Loss/Failure (loss of one or more essential services/internal flood), interviews with an RN and the DOC.

[740849]

## WRITTEN NOTIFICATION: Communication and Response System

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 20 (b)

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is on at all times.

**Rationale and Summary**
A complaint was received by the Ministry that the home's call bells were not working for three days, affecting resident care.

On a specified date, an annual life and fire safety prevention maintenance inspection was conducted. During the inspection, a technical issue occurred where the power supply was triggered and affected the function of the call bells on one of the floors.

In reviewing email communication sent out by the Director of Environmental Services (DES) to the management team on the next day, a technician from a contractor would be available to service the issue the next morning. A report from the contractor noted that the issue was resolved two days after the specified date.

The DOC confirmed the occurrence of the call bells not working on one of the floors.

There was risk that resident care was compromised when the resident-staff communication and response system was not on at all times.

**Sources**: the home's email communications, Troy's annual life and fire safety prevention maintenance inspection report, CHUBB's service report, interviews with the DES and the DOC.

[740849]

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program, including appropriate use of Personal Protective Equipment (PPE).

**Rationale and Summary**
During an observation on a specified floor on a specified date, a PSW was observed entering and leaving resident rooms without donning and doffing PPE as per the signs posted on the doors that indicated additional precaution requirements.

The resident home area was on an outbreak.

The IPAC Lead confirmed that all staff are expected to follow the instructions and apply the appropriate PPE when entering a room that is on additional precautions. This aligned with the home's PPE policy.

Failure to don the required PPE as per the precautionary signs increases the risk of infection transmission on the unit.

**Sources**: Inspector #000704's observations, interview with the IPAC Lead, The home's Personal Protective Equipment policy.

[000704]

## WRITTEN NOTIFICATION: Reports re Critical Incidents

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.

The licensee has failed to ensure that the Director was informed of an incident on three consecutive dates, where the function of a system within the home was affected for over six hours.

**Rationale and Summary**
A complaint was received by the Ministry that the home's call bells were not working for three days, affecting resident care.

On a specified date, an annual life and fire safety prevention maintenance inspection was conducted. During the inspection, a technical issue occurred where the power supply was triggered and affected the function of the magnetic door locks as well as the call bells on one of the floors.

In reviewing home email communications and a contractor report, the issue was resolved two days later.

The DOC confirmed that a system breakdown in the home should have been reported to the Director as the incident spanned over six hours, however it was not done.

There was risk that Ministry was not involved earlier in the above-mentioned incident that could affect the care and well-being of residents.

**Sources**: the home's email communications, Troy's annual life and fire safety prevention maintenance inspection report, CHUBB's service report, interviews with the DES and the DOC.

[740849]

## WRITTEN NOTIFICATION: Construction, Renovation, etc., of Homes

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 356 (4) (a)

The licensee has failed to ensure that an operational plan was sent to the Director for approval to upgrade their Heating, Ventilation, and Air Conditioning (HVAC) system.

**Rationale and Summary**
On a specified date, the DES stated that there was a plan to upgrade the HVAC system. A rented chiller outside of the building was in place at the time until the new unit was available to install. New wiring was installed on the roof, which resulted in a temporary shutdown of the power within the home. During the power shutdown, a PSW reported no lights in resident's washrooms, which required the PSW to use their personal phone flashlight to assist residents in navigating in their washrooms. The Executive Director (ED) confirmed that the plan was not sent to the Director, but there were plans to submit one.

Failure to notify the Ministry of the operational plan to upgrade the HVAC system reduced the ability of the Ministry to be involved and ensure resident safety during the HVAC upgrade.

**Sources**: Inspector's observations, interviews with a PSW, the DES, and the ED, email communication with the ED.

[740849]

## COMPLIANCE ORDER CO #001 Duty to Protect

**NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
1) Re-train nursing department staff on a specified floor on the home's prevention of abuse and neglect policy.
2) Document the training from step 1, including the date of the education, the staff member who provided the education, and the names of the staff who have completed the training.
3) Conduct random audits for a period of two weeks to ensure two specified residents are not further abused by anyone in the home.
4) Maintain a documented record of the audits conducted in step 3, to include, but not limited to: dates of audit completion, residents audited, results of each audit and corrective actions taken in response to the audits.

**Grounds**
The licensee has failed to ensure that a resident was protected from abuse by anyone.

Section 2 (1) (a) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain. This section also defines verbal abuse

as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”.

**Rationale and Summary**
On a specified date, PSW #107 witnessed PSW #109 using profane language and verbalized words of degrading nature towards the resident. PSW #107 also witnessed PSW #109 causing physical harm to the resident, resulting in the resident to demonstrate an emotional response.

The home’s prevention of abuse and neglect policy states that the organization has a zero-tolerance policy for abuse of a resident by anyone.

An RPN and the DOC indicated that physical and verbal abuse occurred based on PSW #107’s observations.

There was physical and emotional impact to the resident when they were physically and verbally abused by PSW #109.

**Sources**: the home’s investigation notes, interviews with a PSW, an RPN and the DOC, the home’s prevention of abuse and neglect policy.

[740849]

The licensee has failed to ensure that a resident was protected from abuse by anyone.

**Rationale and Summary**
On a specified date, PSW #107 witnessed PSW #109 using profane language and speaking to the resident in an intimidating way that caused the resident to have an emotional response. PSW #107 also witnessed PSW #109 being rough with the resident causing the resident to elicit an emotional response.

The DOC indicated that physical and verbal abuse occurred based on PSW #107’s observations.

There was physical and emotional impact to the resident when they were physically and verbally abused by PSW #109.

**Sources**: the home’s investigation notes, interviews with a PSW, an RPN and the DOC.

[740849]

**This order must be complied with by** August 1, 2023

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.