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: July 29, 2024
Inspection Number: 2024-1280-0002
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-12, 15-19, 2024.

The following intake(s) were inspected in the Complaint Inspection:

- Intake: #00113831 - complaint related to skin and wound concerns
- Intake: #00116335 - complaint related to staffing
- Intake: #00121334 - complaint related to allegation of abuse of a resident

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00120264 - 2789-000025-24 - related to allegation of abuse/neglect of a resident
- Intake: #00111198 - 2789-000025-24 - related to skin and wound concerns
- Intake: #00120460 - 2789-000026-24 - related to Infection Prevention and Control (IPAC)
- Intake: ##00111561 - 2789-000013-24 - related to improper care of a resident
- Intake: #00111561 - 2789-000013-24 - related to an allegation of abuse/neglect of a resident

- Intake: #00112300 - 2789-000014-24 - fall of a resident resulting in injury

The following intake(s) were completed in the CIS Inspection:

- Intake: #00119730 - 2789-000022-24, Intake: #00114229 - 2789-000015-24, Intake 00116346 - 2789-000020-24, and Intake: #00114488 - 2789-000016-24 - related to IPAC
- Intake: #00111497 - 2789-000011-24, Intake: #00120199 - 2789-000023-24 - related to fall of a resident resulting in injury

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
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 (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 license has failed to ensure that the care set out in the plan of care was provided to a resident.

Rationale and Summary
A staff member provided care to a resident during their shift. The resident's clinical records indicated that care was provided independently. However, the resident's care plan indicated that two staff members were required for the care that was provided.

The staff confirmed they had provided the care to the resident independently. The Executive Director (ED) acknowledged that when the staff provided the care independently, it placed the resident at risk for their safety due to the resident's behaviours.

The resident was at risk for their safety when staff did not follow the resident's plan of care.

Sources: Interview with the home's staff and management, a resident's clinical records.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to ensure that every alleged incident of neglect was investigated and appropriate action was taken in response to every such incident.

Rationale and Summary
A resident's substitute decision-maker (SDM) made allegations related to several care areas. The home's investigation notes did not indicate the home's actions related to investigating this allegation.

Both Associate Director of Care (ADOC)'s #120 and #105 acknowledged that this component of the complaint was not investigated.

The ED acknowledged that a thorough investigation should have been completed to ensure all items put forward by the complainant were investigated and appropriate actions were taken in response to the allegation.

Failing to investigate the allegations increased the risk of harm to the resident.

Sources: Critical incident (CI) report, the complainant's email to the home, the home's investigation notes, and interviews with ADOCs and the ED.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under the falls program, including assessments, reassessments, interventions, and resident's responses to interventions, were documented.

Rationale and Summary
A resident sustained a fall that resulted in an injury.

The resident's plan of care did not include the use of an intervention. Staff indicated that a specific intervention was in use, but the resident refused. An observation indicated the resident had the intervention, but it was not being used. After the resident returned from the hospital, it was recommended that another intervention be implemented. It was unclear whether that intervention was ever implemented, but many staff thought it had been and was refused by the resident.

The Interim Director of Care (DOC) confirmed that if an intervention had been implemented and was refused, it should have been documented.

Failing to document the resident's interventions and the resident's responses to interventions put them at risk for an inconsistent plan of care without clear direction, which could lead to increased risk for falls.

Sources: CI report, resident's clinical record; an observation of a resident's room, and interviews with the Interim DOC and other staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that a fall prevention device was readily available to prevent falls for a resident.

Rationale and Summary
A resident had a fall that resulted in an injury. When they returned from the hospital, a staff member documented that they needed a fall prevention device, and the evening staff was to follow up.

An RPN documented and confirmed that a fall prevention device was not in stock after having requested one from the Nurse Manager. A Nurse Manager indicated that if they needed the fall prevention device, they would normally find them in a supply room or the physiotherapist's office. However, on a specified date, they checked both places, and the falls prevention device was not available. An email was written from the Nurse Manager to the ADOCs and the physiotherapist, which indicated they were requesting the fall prevention device for the resident.

Failing to have the fall prevention device readily available put the resident at increased risk for further injury.

Sources: CI report, Resident's clinical record, and interview with the home's staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee has failed to ensure that supplies for skin and wounds were readily available at the home for a resident, which resulted in the resident not receiving a dressing change on multiple days.

Rationale and Summary
A review of the resident's clinical record indicated the resident did not receive a dressing on multiple dates, due to supplies being unavailable. A staff member confirmed they were unable to perform a dressing change for the resident on one of those dates as the supplies were not readily available.

The DOC confirmed that the resident's dressing was not changed on multiple dates due to a lack of supplies, and therefore, this increased the risk of infection for the resident.

Failure to ensure that supplies were readily available for the resident, could lead to a risk of infection for the resident.

Sources: Interview with the home's staff and management, resident's clinical records.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure a resident was provided with proper techniques to assist with eating.

Rationale and Summary
A resident was at high nutritional risk related to their medical condition and was to be fed using a utensil at a specified rate and amount for both food and beverages.

The resident's SDM complained that a staff had been improperly feeding the resident. A PSW confirmed they did not use the appropriate utensil to feed or when they provided the beverage to the resident.

After receiving a complaint from the resident's SDM, a Registered Dietitian (RD) stated they observed an Activation Aide (AA) who also did not use the appropriate utensil when they provided the beverage to the resident.

Another two identified PSWs were also observed failing to utilize the proper techniques to assist resident with feeding and was confirmed with an ADOC.

Failing to use proper techniques to feed the resident put them at risk for choking and aspiration.

Sources: The home's investigation notes, a resident's clinical record, observations, and interviews with the home's staff.

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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee failed to ensure Additional Precautions were followed in the IPAC program, including appropriate selection application, removal, and disposal in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, a PSW did not utilize appropriate PPE when entering a resident's room who was on additional precautions as required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary
A resident was on droplet and contact precautions. A PSW was observed entering the resident's room without donning any personal protective equipment (PPE).

The IPAC Lead acknowledged that the PSW should have worn a gown, a face shield, a mask, and gloves when entering a resident's room that was on droplet and contact precautions.

Failure to ensure that Additional Precautions were followed in the IPAC program led to an increased risk for infection transmission in the home.

Sources: IPAC Standard for Long-Term Care Homes – Additional Requirement 9.1 for Additional Precautions, interview with staff and management in the home, observation of a resident home area on July 10, 2024.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action and any follow-up required.

Rationale and Summary
A resident's SDM made several care related allegations. The home's investigation complaint record did not include the home's actions related to these allegations.

The ED acknowledged the complaint record did not include the actions taken in their response to the complaint.

Failing to document the actions taken by the home put the resident at risk for further harm as the home was unable to identify what practices were successful and which were not.

Sources: CI reports, the home's investigation complaint record, and interviews with the ED and other staff.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that the names of any staff members who discovered the incident were included in the Critical Incident (CI) report involving a resident that was submitted.

Rationale and Summary

A CI was submitted to the Director that indicated a resident had a fall and sustained an injury. The report indicated the resident was found lying on the floor by a PSW. The name of the PSW was not included. The Interim DOC indicated they were unaware of this requirement.

Sources: CI report and an interview with the Interim DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that the Alcohol-Based Hand Rub (ABHR) must not be expired as part of the directive issued by the Chief Medical Officer of Health (CMOH).

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Setting, effective April 2024, under 3.1 IPAC Measures, ABHR must not be expired.

Rationale and Summary
During an observation of a Resident Home Area (RHA) that was on outbreak, a wall mounted ABHR product had expired and remained in use outside a resident's room who was on additional precautions.

The IPAC Lead acknowledged the ABHR was expired and replaced the unit. Failure of the home to ensure that an ABHR was not expired increased the risk of infection transmission on a RHA during an outbreak.

Sources: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (April 2024) 3.1 IPAC Measures, observations of expired ABHR, interviews with staff and management.