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

Public Report

Report Issue Date: December 18, 2024

Inspection Number: 2024-1280-0004

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): November 27-29, 2024, and December 2-6, 2024

The following intake(s) were inspected:

- Intake #00127574/Critical Incident (CI) #2789-000039-24 - related to disease outbreak
- Intake #00131803/CI #2789-000044-24 - related to a missing resident
- Intake #00127080/CI #2789-000036-24 - related to unlawful conduct resulting in risk of harm to residents
- Intake #00122861/CI #2789-000031-24, Intake #00127271/CI #2789-000037-24, Intake #00129471/CI #2789-000043-24 - related to resident physical abuse
- Intake #00128038/CI #2789-000040-24 and Intake #00127356/CI #2789-000038-24 - related to resident abuse and improper care resulting in injury
- Intake #00128042 and Intake: #00133730/CI #2789-000047-24 - complaint related to multiple care concerns
- Intake #00132056/CI #2789-000045-24 - related to fall with injury

The following intake(s) was completed:

- Intake #00123151/CI #2789-000032-24 - related to fall with injury

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary

A resident exited the building when the home's door lock system failed.

A staff stated they were expected to monitor the home's entrance and exit doors. Another staff stated they were not aware that the home's door lock system failed and when they did not see a resident inside their room, they did not notify the registered staff that the resident was missing.

When the home's door lock system failed, and staff failed to monitor the home's entrance and exit doors a resident eloped from the building.

Sources: A resident's clinical records, CI #2789-000044-24, home's policy Code Grey–Infrastructure Loss/Failure, XVIII-K-10.00 (8/2024) and staff interviews

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that staff collaborated in the implementation of a resident's plan of care.

Rationale and Summary

A report indicated that on specified dates, a staff failed to document when a resident refused a specified intervention.

Staff stated they did not communicate when the resident refused a specified intervention. The home stated that when the staff failed to collaborate with the team, a resident developed an altered skin integrity.

When staff failed to collaborate with the team, there was a delayed resident assessment and intervention resulting in altered skin integrity.

Sources: CI #2789-000038-24, home's policy Electronic Documentation by Exception – POC Tasks, VII-J-10.04 (07/2024), a resident's clinical records and staff interviews

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 failed to ensure that a resident was provided assistance as specified in their plan of care.

Rationale and Summary

A complaint was received by the home when a resident sustained an injury during care. The home's investigation notes revealed that staff did not provide the resident's required staff assistance.

Staff confirmed that they did not follow the resident's required staff assistance resulting in the resident sustaining an injury.

Failure to provide the required staff assistance to a resident resulted in injury to a resident.

Sources: A resident's clinical records, home's investigation notes and staff interviews

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the home's policy on zero tolerance of abuse and neglect was complied with.

Rationale and Summary

A resident reported allegations they were physically abused by staff. There were no records to indicate resident assessments related to the alleged abuse or records that the incident was reported to the home's management.

Staff confirmed they did not report the alleged physical abuse and did not complete an assessment to ensure the resident was not injured.

Failure to ensure that an alleged incident of staff to resident physical abuse was reported and that the resident was assessed may have delayed the opportunity to gather information related to the alleged incident and take appropriate action to prevent further harm to the resident.

Sources: A resident's clinical records, home's policy on Prevention of Abuse & Neglect of a Resident, VII-G-10.00 (11/2024) and staff interviews

WRITTEN NOTIFICATION: Reporting and Complaints

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 failed to ensure that an alleged staff to resident abuse resulting in harm were reported to the Director immediately.

Rationale and Summary

i) A complaint was submitted to the home related to an alleged staff to resident abuse resulting in an injury. Another complaint was submitted to the home related to a second alleged staff to resident abuse resulting in injury. The home did not immediately report either suspected incident of abuse of the resident to the Director.

ii) A resident reported allegations of physical abuse by staff. The staff failed to inform the home and the CI report was not submitted to the Director. The CI report was submitted at the time of inspection.

The home confirmed that the above incidents of suspected resident abuse were not reported to the Director immediately.

Sources: CI reports #2789-000031-24, #2789-000037-24, #2789-000047-24 and staff interview

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 3.

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:

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

The licensee failed to report to the Director immediately when the home was informed that a staff was not licensed to practice their profession.

Rationale and Summary

On a specified date, the home received an email alleging that a staff was not licensed to practice their profession.

After four months, the home submitted a CI report after a follow up email was received by the home related to the same issue.

Failure to immediately report to the Director when a staff was not licensed to practice their profession delayed the Director's ability to respond to the incident in a timely manner.

Sources: CI #2789-000036-24, Email complaints, home's Investigation Notes, Complaint Management Program (ON), XXIII-E-10.00 (6/2024) and staff interview

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by an authorized person when they exhibited altered skin integrity.

Rationale and Summary

A resident received treatment related to area altered skin integrity.

The home confirmed that there was no skin and wound assessments and weekly skin and wound assessments completed for the resident related to their skin alteration.

Failure to assess a resident's altered skin integrity increased the risk that an assessment and treatment may not be provided to the resident.

Sources: A resident's clinical records, home's policy, Skin and Wound Management Protocol, VII-G-10.90 (7/2024) and staff interview

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that when a resident exhibited an altered skin integrity, they were reassessed at least weekly by an authorized person.

Rationale and Summary

A resident was prescribed treatment related to their altered skin integrity.

The home confirmed that there was no weekly skin and wound assessment completed for the resident related to their altered skin integrity.

Due to the home failing to ensure that a weekly skin assessment was completed and documented, there was a potential risk of delayed treatment and interventions required to promote healing.

Sources: A resident's clinical records, home's policy, Skin and Wound Management Protocol, VII-G-10.90 (7/2024) and staff interview

WRITTEN NOTIFICATION: Responsive Behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to ensure that a resident's behavioural triggers were identified.

Rationale and Summary
A resident demonstrated responsive behaviours with multiple altercations toward staff and residents. The resident's plan of care did not identify their behavioural triggers.

Staff stated, the resident's behaviours escalated when not assigned to their regular staff. The home confirmed that this was not identified in the resident's plan of care.

Failure to identify a resident's behavioral triggers put both other residents and staff at risk.

Sources: A resident's clinical records and staff interviews

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to implement interventions to minimize the risk of altercations between residents.

Rationale and Summary
A resident was physically aggressive towards another resident while in the home's designated area doing their recreational activity.

A resident's plan of care instructed staff of a specific intervention to minimize aggression between the two residents.

Staff stated they failed to implement the specified intervention to ensure that altercations between two residents were minimized while doing their recreational activity.

Sources: A resident's clinical records and staff interviews

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #011 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 has failed to ensure any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

The licensee failed to implement measures in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard). Specifically, Additional Precaution 9.1 (f) under IPAC standard required proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal and disposal.

Rationale and Summary
A resident was on isolation due to respiratory symptoms pending laboratory results. Their bedroom door had an enhanced IPAC precaution signage posted with PPE caddy available at Point of Care (POC).

A staff entered the room and provided assistance to the resident wearing only their surgical mask.

The home stated staff were expected to wear the required PPE as posted outside of a residents' bedroom door when coming in two meters of a resident who was on isolation.

There was an increased risk of infectious disease transmission when staff did not wear the required PPE for residents on enhanced IPAC precaution.

Sources: Observations in the home, IPAC Standard for Long Term Care Homes, April 2022, Resident list on enhanced IPAC precautions and staff interviews

WRITTEN NOTIFICATION: Reporting and Complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. i.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,

The licensee has failed to ensure the Director was informed within one business day of a breakdown or failure of the security system that lasted more than six hours.

Rationale and Summary
The home's door lock system failed for more than six hours.

The management stated they were made aware of the system failure but failed to report the incident to the Director.

Failure to submit a critical incident report to the Director, posed a potential risk to the building's safety and security.

Sources: The Critical Incident System and staff interview

WRITTEN NOTIFICATION: Reporting and Complaints

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed in no later than one business day when a resident was sent to the hospital after an incident that resulted in a significant health change.

Rationale and Summary

A resident was transferred to the hospital after an incident and returned to the home with a new diagnosis. A CI report was submitted four days after the resident was readmitted to the home.

Staff stated the resident's care needs changed, upon return from the hospital. The home stated the Director should have been informed within one business day after they confirmed the significant health change.

Sources: CI #2852-000072-24, a resident's clinical records and staff interviews

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 139 2. i.

Security of drug supply

s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

The licensee has failed to ensure security of the drug supply, when a staff had access to all areas where drugs were stored at a time when they were not licensed to practice their profession.

Rationale and Summary

A staff member worked in the home as a Registered Practical Nurse (RPN) during a time in which they had no license to practice their profession upon hire and later worked under an expired and suspended license.

The staff stated they were hired as a regulated health professional and held medication room keys during their shift including narcotics.

There was a risk of harm to residents when a staff had access to medication storage including narcotics without a license or when their license expired.

Sources: A staff employee file, College of Nurses of Ontario (CNO) public website, review of Medication Audits for a staff and staff interviews

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3)
Administration of drugs
s. 140 (3) Subject to subsections (4), (5) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse.

The licensee has failed to ensure that when a staff administered drugs to residents in the home they were a member of a regulated health profession and was acting within their scope of practice.

Rationale and Summary
A staff worked as an RPN in different shifts on all floors in the home,

The home stated that as an RPN, they completed assessments, provided treatments, administered medications, including narcotics to residents.

There was a risk of harm to residents when an RPN worked in a capacity of a regulated health professional when they were not registered and or when their license expired.

Sources: A staff employee file, CNO public website. review of Medication Audits for a staff and staff interviews

COMPLIANCE ORDER CO #001 Certification of Nurses

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 51
Certification of nurses
s. 51. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 51 [FLTCA, 2021, s. 155 (1) (b)]:

Please submit the written plan for achieving compliance for inspection #2024-1280-0004 by email by January 7, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

The plan must include but is not limited to:
(a) Immediately audit the CNO registration of all registered staff working in the home
(b) Develop a system to verify nursing registration annually
(c) Individuals in the home who assist in hiring receive training on how the CNO application of temporary license form is completed.
(d) Individuals in the home who assist in hiring receive training on items (a), (b) and (c)
(e) Maintain a records of audits and trainings completed, including but not limited to,

content of the trainings, date of audit & trainings, person completing the audit & trainings, outcome and actions taken as a result of any deficiencies identified.

Grounds
The licensee has failed to ensure that a staff had the appropriate current certificate of registration with their college.

Rationale and Summary
A staff worked as an RPN for a period in the home. The RPN was not licensed to practice upon hire and later worked under an expired and suspended license.

The RPN's condition of employment indicated a temporary registration from their college prior to their start date and a valid registration after their temporary license expired. The home's recruitment process indicated that when screening applicants, all registered applicants must be verified through their college and to ensure they were in good standing.

The home stated they did not verify if the RPN had their temporary license prior to their start date and confirmed that there was no temporary license in their file. The home was only made aware that the RPN was not entitled to practice when they were hired and that their license was not current on a specified date.

Failure to verify a staff's entitlement to practice posed a risk of harm to the residents in the home.

Sources: A staff employee file, Offer letter Appendix B Completion of School-RPN Student, New Hire Employee File Checklist III-H-10.00 (b), CNO Temporary Class Offer of Employment Form, CNO public website, home's policies on Team Member Files, III-H-10.10 (10/2024), Orientation and Onboarding, III-C-10.10 (12/2023) and staff interviews

This order must be complied with by January 30, 2025

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.