Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

# Rapport d'inspection prévue 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**

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 17, 2019 | 2019_516734_0007 | 024804-17, 027882-17, 011562-18, 002304-19 | Complaint |

## Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Langstaff Square Care Community
170 Red Maple Road RICHMOND HILL ON L4B 4T8

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

JADY NUGENT (734), ANGIEM KING (644)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): July 8 - July 12, 2019.**

**The following complaints were inspected upon:**

**Log #024804-17, related to responsive behaviours;**

**Log #027882-17, related to improper care;**

**Log #011562-18, related to medication error; and**

**Log #002304-19, related to an improper transfer.**

**During the course of the inspection, the inspector(s) spoke with Medical Director - Physician, Director of Care (DOC), previous Acting Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Pharmacy Consultant, Resident Relations Coordinator, Facility Staff, family members and residents.**

**The inspectors also made observations of residents and their home areas; and reviewed relevant administrative health records for specified residents.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Skin and Wound Care**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, by Substitute Decision Maker (SDM) #110 regarding a medication that was ordered for resident #003. SDM #110 stated that resident #003 was ordered this medication for a medical condition for which the resident did not have. SDM #110 also voiced concerns included not being notified when resident #003 was started on the new medication.

Review of resident #003's Full Minimum Data Set (MDS) assessment on an identified date, revealed that resident #003 diagnoses did not include the said medical condition.

Review of the physician's orders for resident #003 revealed an order written on an identified date, for a specific medication, dosage and monitoring instructions.

Review of the electronic medication administration record (eMAR) for resident #003 revealed the said medication was administered on specific dates.

A progress note dated on an identified date, revealed an entry by RN #120, which stated that SDM #110 AND #112 visited resident #003 at which time they notified them that the resident was taking a specified medication. SDM #112 stated they did not want the resident to take this medication.

In separate interviews, RPNs #111, #114, #116, RN #105 and #119 stated the SDM was to be notified for new medication or changes in medication orders.

In an interview, RPN #118 stated that they had transcribed the physician order on an identified date, and did not inform the SDM of the new medication. They further stated it is the expectation of the home to notify the SDM of new medication orders.

In an interview, SDM #112 stated that no one had informed them that there was a change in resident #003's medication. They stated that they were informed by review of the pharmacy's medication invoice for resident 003's and upon visiting the resident is when they noticed resident #003 was not their usual self. RN #120 had then informed them of the new medication and that tests were being completed.

In an interview, RN #120 stated that they were working as the nurse on an identified date when the family visited. The RN further stated they had communicated to SDM #110 and #112 on the above date about resident #003's plan of care included the new medication and testing, they did not know that the SDMs were not informed.

In an interview, DOC #115 stated that the home's expectation is when resident #003 was ordered the medication that the registered staff should have contacted SDM #112 so that they could be provided the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

---

**Issued on this 18th day of July, 2019**

[redacted]

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

**Original report signed by the inspector.**