Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2021	2021_947752_0005	010485-21, 010684-21, 012022-21	Critical Incident System

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

LUCIA KWOK (752)

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): November 8, 9, 10, 12, 16, 17, and 18, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
A follow up log to Compliance Order (CO) #001, LTCHA, 2007 S.O. 2007, c.8, s. 6. (7), related to plan of care and falls prevention intervention, issued under inspection #2021_823653_0015, on June 28, 2021, with a compliance date of September 13, 2021, was inspected;
a log related to alleged staff to resident neglect;
a log related to resident fall resulting in significant change in health status.

During the course of the inspection, the inspector(s) spoke with residents, housekeeping staff, Personal Support Workers (PSW), activation staff, receptionist, PSW student, Registered Practical Nurses (RPN), Registered Nurses (RN), the Infection Prevention and Control (IPAC) lead, the Assistance Director of Care (ADOC), the Director of Care (DOC), and the Executive Director (ED).
During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed resident and staff interactions, reviewd relevant policies and procedures, and reviewed pertinent resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_823653_0015	752

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	Légende 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program (IPAC). Specifically, staff did not assist

residents with hand hygiene (HH) before and after snack and meal service, cleaning of shared resident equipment, and availability of personal protective equipment (PPE).

a) Observations of HH practices were conducted during the inspection. There was no HH offered to 11 different residents before and/or after meal and/or snack services.

A resident indicated that staff did not provide assistance with HH prior and after snack service.

RPN #116 stated that the expectation was for staff to assist residents with HH before and after meals and/or snack service. PSW #117 acknowledged that HH was not provided to residents after meal service.

Sources: Observation (staff and resident hand hygiene practices) on November 8, 9, 10, 18, 2021; Interviews with residents, IPAC lead, and staff; Hand Hygiene policy #IX-G-10.10, revised April 2019.

b) Inspector #752 observed two PSWs entered a resident room with a assistive device. PSW #107 stated that they had used the assistive device to provide direct care to the resident and cleaned the assistive device with hand sanitizer and paper towel in the resident's room after use.

The IPAC lead stated that shared resident equipment were to be cleaned between each resident use with one minute Virox wipes.

Sources: Observation (equipment cleaning practice); Interview with PSW #107 and IPAC lead; Equipment Cleaning- Resident Care and Medical policy, #IX-G-20.90, revised June 2020.

c) Two residents' clinical records indicated that they were on additional precautions.

On two occasions, the personal protective equipment (PPE) caddie outside of one of the resident's room was not stocked with the required supplies.

The IPAC lead stated that PPE caddies outside of additional precautions rooms should be stocked with the required supplies. PSW #107 stated that staff were responsible to ensure the PPE caddies were stocked adequately.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations (staff IPAC practices); Interviews with PSW #107 and IPAC lead; Additional Precautions policy #IX-G-10.70, revised April 2019, clinical records. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to Infection Prevention and Control (IPAC) measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which had been issued to Long-Term Care Homes (LTCHs), and set out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. Universal surgical masks were to be worn by staff and visitors at all times in the home.

There were four different instances when staff members and one instance when a visitor were observed to be in a resident home area or in close proximity with other staff and/or residents with improperly applied mask and/or no mask.

By not adhering to the measures set out in Directive #3 related to universal masking, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations (staff PPE practices) on November 9, 10, and 16, 2021; Interviews with IPAC lead; Directive #3 (July 16, 2021). [s. 5.]

WN #3: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care as it related to falls interventions, was provided to two residents as specified in the plan.

The following is further evidence to support the order issued on June 28, 2021, during inspection #2021_823653_0015, to be compiled by September 13, 2021.

a) A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to a resident's fall resulting in a significant change in health condition. The resident's care plan indicated they were at high risk for falls, and among the listed interventions included wearing of non-slip socks. The resident's care plan indicated that they required assistance to specific activities of daily living (ADL) before and after each meal, and frequent monitoring as these were their fall risk factors.

The resident was observed sitting in their wheelchair in the hallway by the nursing station without their non-slip socks. On another occasion, the resident was observed to have complete their ADL on their own. PSW #119 stated that the resident was able to transfer themselves and required close monitoring from staff. The PSW stated that they were short staffed and was unable to provide ADL assistance to the resident after meal.

Sources: Observations on November 12, and 18, 2021; Interviews with PSW #119 and staff; progress notes, plan of care.

b) A resident's care plan indicated they were at moderate risk for falls, and among the listed interventions included two floor mattresses on both sides when they were in bed.

The resident was observed resting in their bed without floor mats on either side of the bed.

PSW #104 stated that staff were to review a resident's plan of care to identify the falls prevention interventions in place.

By not ensuring the residents' fall prevention interventions were provided as per their plan of care, there was potential risk of harm to the residents as there was potential for another fall and injuries.

Sources: Observations on November 12, 2021; Interview with ADOC/Falls program lead, PSW #104; plan of care. [s. 6. (7)]

Issued on this 16th day of December, 2021

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

Original report signed by the inspector.