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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 25, 2023

Inspection Number: 2023-1391-0004

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Langstaff Square Care Community, Richmond Hill

Lead Inspector	**Inspector Digital Signature**
AngieM King (644)	Angeli M King Digitally signed by Angeli M King Date: 2023.09.13 08:39:20 -04'00'

Additional Inspector(s)
Carole Ma (741725)
Tiffany Forde (741746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17 - 21, 24 - 28, 2023

The following intakes were completed in this Critical Incident (CI) inspection:
- Three intakes related to staff to resident abuse
- An intake related to an injury of unknown cause
- An intake related to resident neglect

The following intakes were completed in this Complaint inspection:
- Two intakes related to residents' bill of rights, retaliation, policies, spousal reunification, COVID-19 policies
- An intake related to medication administration, retaliation, staff to resident abuse and neglect
- An intake related to documentation, not reporting death, policies, plan of care.

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

Resident Care and Support Services

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 8.

The licensee failed to ensure that a resident's privacy was maintained to the Residents' Bill of Rights.

Rationale and Summary
The Director received a critical incident report (CIR) regarding an incident that took place in March 2022. A Personal Support Worker (PSW) received a text message from another PSW regarding resident's care and their personal health information. Staff failed to maintain the resident's privacy and protect resident's personal information under the Personal Health Information Protection Act (PHIPA) when personal health information were sent to personal devices. This action put the resident at risk, with sharing of personal health information over an unprotected network without consent.

The PSW confirmed the resident's personal information were sent to their cellular device. The Executive Director (ED) acknowledged the resident's dignity was not maintained when personal health information were taken and sent. Investigative notes were reviewed in detail, the PSW acknowledged personal health information were taken without consent and resident rights was not protected as well as the resident's dignity.

Failure to protect the resident's dignity and privacy caused emotional and mental stress to the resident and their family.

Sources: CIR, home's investigative notes, personal health information, interviews with PSW and ED. [741746]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

Non-compliance with s. 24 (1) 2 under the Long-Term Care Homes Act, 2007 and s. 28 (1) 2 under Fixing Long-Term Care Act, 2021.

The licensee has failed to ensure that staff members who had reasonable grounds to suspect abuse of two residents that resulted in harm or a risk of harm to the residents, immediately reported the suspicion and the information to the Director.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 24 (1) 2 of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 28 (1) 2 of the FLTCA.

Rationale and Summary
1) Non-compliance with s. 24 (1) 2 under LTCHA, 2007
The home submitted a CIR to the Director, related to personal information of a resident which were sent to a PSW.

The Director of Care (DOC) confirmed the home did not immediately report suspicion of abuse and submitted the CIR 19 days after the incident occurred. The PSW acknowledged they failed to report the abuse of the resident when they initially received the information.

Failing to ensure that the Director was notified immediately placed no risk to the resident.

Sources: CIR, home's investigative notes, resident's clinical record, interviews with PSW, DOC and ED. [741746]

2) Non-compliance with s. 28 (1) 2 under FLTCA, 2021
The home submitted a CIR to the Director related to a PSW punching a resident.

The DOC was informed of the incident on the day it occurred. They confirmed the home did not immediately report the suspicion of abuse and submitted the CIR one day after.

Failing to ensure that the Director was notified immediately placed no risk to the resident.

Sources: CIR, interview with DOC. [741725]

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 ensure that the home's written policy on zero tolerance for abuse was complied with.

Rationale and Summary
A CIR was submitted to the Director related to an alleged abuse incident of a resident by a PSW.

The home's Prevention of Abuse & Neglect of a Resident policy, VII-G-10.00, last revised October 2022, states all residents have the right to dignity, respect, freedom from neglect, and to be protected from abuse. The organization has a Zero Tolerance policy for abuse of a resident by anyone and neglect of a resident by the community or one of its team members. Abuse and neglect are not tolerated in any circumstance.

Registered Nurse (RN) stated to the Inspector that the resident's family provided video surveillance taken from the resident's room that revealed a PSW had forcefully pushed the resident onto their bed. The RN reported the alleged incident of physical abuse immediately to the Director of Care (DOC). The resident was assessed by the RN with no complaints of pain or injury.

The RN and the DOC acknowledged that the actions of the PSW towards the resident constituted abuse. The DOC confirmed that the two PSWs at the time of the incident, their employment was terminated. Both PSWs were no longer employed in the home to be interviewed.

Failure to protect the resident from abuse put them at risk of physical harm and could have negatively impacted the resident's quality of life.

Sources: CIR, home's investigation notes, home's Prevention of Abuse & Neglect of a Resident policy, VII-G-10.00, video surveillance, resident's clinical health records, interviews with RN and DOC. [644]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision maker (SDM), was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A complaint was made to the Director on a specific date by an SDM indicating that a resident had not received a medical intervention, despite a consent form being provided to the home

On a specified date, the Infection Prevention and Control (IPAC) lead indicated the home had notified family members of an upcoming clinic for the medical intervention. The resident's clinical records showed that a voice message from the ED was sent to four phone numbers, three of which belonged to SDMs, and a voice mail was left for the SDMs a week before the clinic date.

The message indicated that the clinic to provide the medical intervention would occur on a specific date. The message did not provide a time for when the clinic would be held that day, nor a deadline for when consent forms needed to be received.

A consent form for the resident to participate in the clinic was signed by an SDM and dated for the day before the scheduled clinic. The receptionist indicated that the consent form may have been left at their desk on either the day before or, the day of the clinic, as it was initialed, and date stamped by them for the day of the clinic. As per their process, the consent form would then have been placed in the manager's mailbox in a timely fashion.

The IPAC lead indicated the resident's consent form was not received in time for the clinic. They also acknowledged the family was not made aware that the resident had not received the medical intervention until the resident had a change in health status, during an outbreak.

The SDM indicated that had the family been made aware that the resident had not received the medical intervention, they would have taken the resident outside of the home to ensure it was completed.

In failing to ensure that the SDM was given an opportunity to participate fully in the implementation of the resident's plan of care, the resident's status for this medical intervention was not up to date.

Sources: Resident's clinical records, email correspondence between the SDM and ED, home's announcement of clinic, interviews with SDM, Receptionist, IPAC lead. [741725]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that a resident's plan of care was followed when the PSW showered them independently resulting in a fall.

Rationale and Summary
A CIR was submitted to the Director regarding a fall of a resident which resulted in a transfer to the hospital. The resident's plan of care indicated the resident was at risk for falls, and among the listed interventions included two-person assist for showers related to responsive behaviors. The PSW

acknowledged during an interview that they did not check the plan of care prior to giving the resident a shower. The resident was known to have responsive behaviors at times, which required another staff to be present.

Failure to follow the plan of care resulted in the resident's fall and transfer to hospital.

Sources: Resident's plan of care, home's investigative notes, interview with PSW #107. [741746]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE-LICENSEE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director two written complaints that it received from a resident's SDM concerning care of the resident.

Rationale and Summary
A complaint was made to the Director on a specific date by an SDM, related to care provided to a resident.

On a specified date, the SDM had emailed the Family Council (FC) with a series of complaints related to specific care concerns. With the SDM's consent, the FC forwarded the complaint email to the ED and Vice-President (VP) of Operations. Later that same day, the SDM informed the FC that they had received a phone call from the ED who indicated that they had opened up an investigation to resolve the concerns.

Approximately seven months later, the SDM sent a complaint email to the ED related to additional resident care concerns and asked for an explanation for the resident not receiving a medical intervention despite a signed consent form having been provided.

The ED indicated they would check if any CIRs had been submitted to the Director related to the written complaints from the SDM. They were unable to produce records of any relevant CIR submissions.

The home's complaint management policy stated that any complaint that alleges harm or risk of harm, including, but not limited to physical harm, to one or more residents, must be forwarded to the MLTC (Director) as per Ministry regulations.

There was no impact to the resident with the home failing to submit a CIR.

Sources: Home's complaint management policy, email correspondences from SDM, FC and ED, interviews with SDM and ED. [741725]

WRITTEN NOTIFICATION: NOTIFICATION RE: INCIDENTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)

The licensee has failed to ensure that a resident's SDM was notified immediately upon the licensee becoming aware of a witnessed incident of abuse of the resident that resulted in a physical injury and pain to the resident, and that caused distress to the resident that was potentially detrimental to the resident's health or well-being.

Rationale and Summary
A complaint was made to the Director by an SDM that a resident was assaulted by a PSW on a specific date and that they were not notified until the following the day.

The DOC indicated the home first learned of this incident on a specific date, when a Care Support Assistant (CSA) reported what they had witnessed.

The home began an investigation on the day of the incident, and the CSA confirmed that they saw a PSW punch the resident with a closed fist to a specific part of the body, which resulted in redness at the site. The resident reportedly screamed in pain and said it hurt them and that they were disappointed in what happened.

On the following day, the ED documented in the resident's clinical records that they had met with the SDM and provided them with information related to the abuse.

In failing to immediately notify the SDM of the physical abuse, the resident was denied immediate comfort and emotional support from a family member.

Sources: Resident's clinical records, home's investigation notes, interviews with SDM and DOC. [741725]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that a written complaint from a resident's SDM concerning the care of the resident was investigated and resolved where possible, and that a response within 10 business days of the receipt of the complaint was provided to the SDM.

Rationale and Summary
A complaint was made to the Director by an SDM related to care provided to a resident.

On a specified date, the SDM had emailed the FC with a series of complaints related to specific care concerns. With the SDM's consent, the FC forwarded the complaint email to the ED and VP of Operations. Later that same day, the SDM informed the FC that they had received a phone call from the ED who indicated that they had opened up an investigation to resolve the concerns.

Four months later, the FC emailed the ED and indicated that they were informed by the SDM, that the complaints detailed earlier in the email were left unresolved. They indicated that the family should have received a response back within 10 days.

Three months later, the SDM sent a complaint email to the ED related to additional care concerns for the resident, and asked for an explanation as to why the resident had not received the medical intervention despite a signed consent form having been provided.

A month later, the SDM indicated they still had not heard back from the home related to the emailed complaints.

The ED indicated that they could not recall if an investigation had been conducted for these concerns, given numerous meetings and impromptu conversations they have had with family members on a frequent basis.

The home's complaint management policy stated that for written complaints, the ED or designate would conduct and document an internal investigation and provide a written response to the complainant within 10 days of receipt. If the complaint could not be resolved within 10 business days, the home would provide an acknowledgment of receipt within 10 business days to the complainant, including the date by which the complainant could expect a resolution and follow-up response. The investigation must be concluded in 21 days and if not possible, a reason would be documented in the investigation notes.

In failing to ensure SDM's emailed complaints were investigated and resolved, and that the family received a response, the resident was placed at risk for repeated care concerns, and the family's trust in the home's management team and complaints process was eroded.

Sources: Home's complaint management policy, email correspondences, interviews with SDM and ED. [741725]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record is kept in the home that includes, the nature of each verbal or written complaint.

Rationale and Summary
A complaint was made to the Director by a SDM, related to care provided to a resident.

On a specified date, the SDM had emailed the FC with a series of complaints related to specific care concerns. With the SDM's consent, the FC forwarded the complaint email to the ED and VP of Operations. Later that same day, the SDM informed the FC that they had received a phone call from the ED who indicated that they had opened up an investigation to resolve the concerns.

Seven months later, the SDM sent a complaint email to the ED related to specific care concerns for the resident, and asked for an explanation as to why the resident had not received the medical intervention despite a signed consent form having been provided.

In reviewing the home's complaint logs, neither of the SDM's written complaints were included. The ED acknowledged that they could not provide an explanation for this omission.

The home's complaint management policy stated the ED or designate would file the complaint information, complaint record, and any other investigation notes in a Complaints Management Binder and that all complaints must be logged, and any follow up noted.

In failing to include the SDM's written complaints in the home's complaint log, concerns related to the resident's care remained untracked and unresolved.

Sources: Home's complaint management policy, email correspondence, home's complaint log, interview with ED. [741725]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #010 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. Ensure all PSWs on Miles Hill and Dexter Road resident home areas are retrained by the DOC on the home's prevention of abuse policy, residents' bill of rights, and how to manage residents demonstrating responsive behaviours during care. Document the contents of this education as well as the date, those providing and receiving the education and make available for Inspectors upon request.

2. Ensure the DOC or management designate conduct weekly audits of reported incidents of abuse for a period of two months, to ensure that the licensee's abuse policy is being complied with.

3. Keep a documented record of all audits completed for a period of two months, noting any corrective actions taken and make available for Inspectors upon request.

Grounds
The licensee failed to ensure that two residents were protected from abuse by staff members.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 19 (1) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 24 (1) of the FLTCA.

Rationale and Summary
1) Non-compliance with s. 19 (1) under LTCHA, 2007
Section 2 of the Ontario Regulation 79/10 defined sexual abuse as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

The home submitted a CIR to the Director, related to personal health information of a resident which were sent to a PSW's personal device. The resident's plan of care indicated they were cognitively impaired, and the resident required extensive assistance for all activities of daily living (ADL). The PSW acknowledged the personal health information were taken without consent. The ED acknowledged that when the PSW took sexually explicit personal health information of a resident, their dignity was not respected.

Failure to protect the resident from the PSW's actions put them at risk for physical and emotional harm.

Sources: Home's Prevention of Abuse & Neglect of a Resident, Policy VII-G-10.00 last revised October 2022, home's investigative notes, personal health information, interviews with the PSW and ED. [741746]

2) Non-compliance with s. 24 (1) under FLTCA, 2021
Under FLTCA, 2021, the Ontario Regulation 246/22, section 2 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A complaint and CIR were submitted to the Director related to an assault of a resident by a PSW.

The home conducted an investigation where a CSA confirmed in an interview and in a written statement that they saw the PSW punch the resident with a closed fist on a specific part of their body that left redness at the site. The resident reportedly screamed in pain and said it hurt them and that they were

disappointed it happened.

The resident's clinical records documented that an assessment was completed after the incident and the resident had mild tenderness in the area of being hit.

The DOC confirmed that based upon a witness report and the assessment findings, the home determined that the abuse occurred. The PSW was terminated on a specific date.

In failing to ensure the resident was protected from physical abuse by staff, the resident experienced pain and emotional harm.

Sources: CIR, resident's clinical records, home's investigation notes, Interview with DOC. [741725]

This order must be complied with by October 27, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior non-compliance with LTCHA 2007, s. 19 (1), resulting in Compliance Order (CO) #002 from inspection #2022_941746_0008, issued on April 20, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By

submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.