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: November 29, 2023

Inspection Number: 2023-1391-0005

Inspection Type:
Complaint
Critical Incident
Follow up

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

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

Lead Inspector	**Inspector Digital Signature**
Marian Keith (741757)	Marian P Keith Digitally signed by Marian P Keith Date: 2023.12.17 14:12:07 -05'00'

Additional Inspector(s)
Jennifer Brown (647)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 2023.

The following intake(s) were inspected:

- An intake – First Follow-up to Compliance Order #001 related to duty to protect.
- An intake relating to a resident fall.
- An intake relating to resident council.
- An intake relating to resident care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1391-0004 related to FLTCA, 2021, s. 24 (1) inspected by Marian Keith (741757)

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

Resident Care and Support Services
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of Licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2023-1391-0004 served on August 25, 2023, with a compliance due date of October 27, 2023.

The required retraining of all personal support workers (PSWs) on specific resident home areas was not completed.

Rationale and Summary:

The Director of Care (DOC) did not complete the required retraining for all PSWs on Miles Hill and Dexter Road resident home areas (RHAs) for the home's prevention of abuse policy, residents' bill of rights and how to manage residents who demonstrated responsive behaviors during care.

Nursing schedules identified 55 different PSWs working between the dates of August 27-October 27, 2023 on Miles Hill and Dexter Road RHAs. Records for retraining included informal notes from the DOC and Administrator's notebooks and identified 35 out of the 55 PSWs were retrained, which is a 64 percent (%) completion rate.

The DOC indicated that over 90% of staff were trained and that some of the training was completed informally and were informally documented.

Failure to comply with the requirements of the compliance order had no direct impact to residents.

Sources: CO #001 from Inspection #2023-1391-0004, Training records for CO #001, Notes from DOC and Administrator's notebook, Nursing schedules, Interview with DOC.
[741757]

An Administrative Monetary Penalty (AMP) is being issued on this written notification 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 Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 an order under s. 155 of the Act.

Compliance History:

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.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to support a resident with hand hygiene prior to a meal.

Rationale and Summary:

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, Additional Requirements Under the Standard, section. 10.4 directs the licensee to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as, under section. 10.4 h) support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

During the tour of the home, Inspector #741757 observed lunch tray service for a resident. The resident was set up with lunch tray by PSW #104 and they left the room without offering hand hygiene to the resident prior to eating their meal.

PSW #104 indicated after the observation that resident only prefers hand hygiene after meals. The resident confirmed that they wished staff would offer them hand hygiene before and after meals. They had no preference indicated in their written care plan. The Infection Prevention and Control (IPAC) Lead confirmed that the expectation for residents receiving their meals via tray service in their rooms, that the PSW delivering the tray would assist the residents with hand hygiene before and after assisting with their trays.

Failure to assist residents with hand hygiene prior to meals increases the risk of transmission of germs or infectious agents from surfaces or objects directly to residents through the process of eating with unwashed hands.

Sources: Observation, Interview with resident, PSW #104, IPAC Lead.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to inform the Director within one business day of an incident of a fall that caused injury to a resident for which the resident was taken to the hospital and that resulted in significant change in the resident's health condition.

Rationale and Summary:
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) for an incident involving the fall of a resident and their transfer to an outside facility.

The resident's fall resulted in a significant change to their condition and the home was informed of this on the same day.

The DOC indicated that the expectation of the home when notifying the Director of an incident where a resident is taken to the hospital, and it is known that there has been a significant change in their condition is three days.

Failure to submit the critical incident report within the expected timeframe risks delay in notifying the Director of the incident, but has no direct risk or impact to the resident.

Sources: CI, Resident's clinical records, interview with DOC.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)

The licensee failed to ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident.

Rationale and Summary:

During the tour of the home, Inspector #741757 observed lunch tray service for a resident. The resident was set up with lunch tray by PSW #104 and they left the room. Upon entry into resident's room for interview, inspector observed resident to be taking noon dose of medications.

Registered Practical Nurse (RPN) #103 confirmed the medications were brought down and left with the resident and follow up had not taken place to ensure they had taken the medications. The Director of Care (DOC) confirmed there were no residents who met the criteria for self-administration of medications and the registered staff must be present while the resident is taking the medications.

Failure to follow appropriate procedure for the administration of medications to residents increases the risk of residents not effectively taking their medications on time, choking without supervision, dropping or saving medications, or identifying refusal or inability to take medications. There is also risk of other residents having access to those medications and taking them.

Sources: Observations, Resident's clinical records, home's 'The Medication Pass Policy', interviews with RPN #103 and DOC.

[741757]