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
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 17, 2024
Inspection Number: 2024-1391-0004
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25- 28, 2024, and July 2-5, 2024.
The inspection occurred offsite on the following date(s): July 4, 2024

The following intake(s) were inspected:
An intake related to alleged resident-to-resident physical abuse.
An intake related to alleged resident-to-resident physical abuse.
An intake related to a complaint related to menu planning and alleged staff-to-resident abuse.
An intake related to a complaint related to a resident's care.
An intake related to alleged staff-to-resident neglect.
An intake related to an unwitnessed fall of a resident resulted in an injury.
An intake related to Follow-up #:1- O. Reg. 246/22 - s. 140 (4) (b)
An intake related to Follow-up #:2- O. Reg. 246/22 - s. 140 (4) (d)
An intake related to Follow-up #:3- FLTCA 2021, - s. 5.
An intake related to a complaint regarding resident care plan concerns.
An intake related to a complaint regarding an allegation of staff to resident abuse and LTCH's response.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1391-0002 related to O. Reg. 246/22, s. 140 (4) (b) inspected by Eric Tang (529)

Order #002 from Inspection #2024-1391-0002 related to O. Reg. 246/22, s. 140 (4) (d) inspected by Eric Tang (529)

Order #003 from Inspection #2024-1391-0002 related to FLTCA, 2021, s. 5 inspected by Eric Tang (529)

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

Continence Care
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care
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.

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

Rationale and Summary

A complaint was submitted to the Ministry of Long-Term Care (MLTC) regarding the Long-Term Care Home (LTCH), which did not inform the SDM of the resident's health condition.

The resident's record review indicated that the Physician identified a skin integrity alteration and on the next day, a Registered Practical Nurse (RPN) conducted a skin assessment. There was no documentation indicated the SDM was informed regarding this new skin alteration. The RPN indicated that the SDM was not notified about this new skin alteration. The Executive Director (ED) confirmed the home was expected to inform the SDM if there was any new skin alteration and the staff failed to inform the resident's SDM.

When the licensee failed to inform the resident's SDM, the resident's SDM was not allowed to participate fully in the development and implementation of the resident's plan of care.

Source: Resident's electronic records, interviews with RPN and ED, and home policy for skin and wound care management Protocol.

WRITTEN NOTIFICATION: Complaints, procedures-licensee

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward the Director any written complaint received concerning the care of a resident in the home.

Rationale and Summary

A complaint was received by the Director related to the care provided to a resident.

During an identified period, the resident's SDM e-mailed the Director of Care (DOC) and ED multiple times with complaints regarding concerns about the resident's care.

The ED and DOC acknowledged that the written complaints concerning the care of the resident were not forwarded to the Director.

Failure to ensure that the Director was informed of any concerns related to the care provided to the resident could lead to further risk for the resident.

Sources: email correspondence between the SDM, DOC, and ED, interviews with ED and DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written complaint from the 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 received by the Director related to the care provided to a resident.

A review of the emails between the SDM and the home's leadership team members revealed multiple complaints regarding the care of the resident between an identified period. The SDM did not receive the investigation's outcomes or information on whether the complaints were resolved.

The home's Complaints Management Program Policy indicated that any complaint shall be investigated, and actions shall be taken for resolution. The ED or designate will conduct and document an internal investigation using the Complaint Record Form and provide a written response to the complainant within 10 days of receipt.

Further, in the event a complaint cannot be resolved within 10 business days, provide an acknowledgment of receipt within 10 business days to the complainant, including the date by which the complainant can expect a resolution and follow-up response. The investigation must be concluded in 21 days; if this is not possible due

to circumstances beyond the control of the community, document the reason for the delay in the investigation notes.

The SDM indicated that they had not received any written responses from the leadership team members regarding the outcomes of the investigations and resolutions to their complaints.

The home's ED, DOC, and ADOC could not recall if an investigation had been conducted for these concerns, given their regular impromptu conversations with the resident's SDM. They assumed the concerns had been resolved.

ED and DOC confirmed that the SDM was not provided with a written response to the investigation of their concerns, and the home's complaints program was not followed.

Failure to promptly investigate and resolve SDM's written complaints placed the resident at risk of ongoing care concerns and undermined the trust of the family in the home's management team and complaints process.

Sources: Home's Complaint Management Program, email correspondence between SDM, DOC, and ED, interviews with SDM and ED, DOC, and ADOC.

COMPLIANCE ORDER CO #001 Plan of care - Integration of assessments, care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A. Conduct an interdisciplinary meeting to review all aspects of the resident's continence care. The meeting shall involve a representative of Sienna medical services and clinical team, the home's leadership team and medical director, and a representative of Mackenzie Health Nurse-Lead Outreach Team (NLOT). Record detailed documentation of the meeting discussions, dates of the meetings, the attendees, and the action plan. Provide the records upon the inspector's request.

B. Develop and implement a written plan of care for the resident that includes all aspects of their continence care management. The plan should be integrated and consistent with the resident's needs to promote comfort and avoid preventable transfers to the hospital.

C. The home's leadership team is to collaborate with the resident's SDM on the development and implementation of the resident's care, plan of care, and any changes. The home is to retain written records of all interactions with the resident's SDM and provide the records upon the inspector's request.

Grounds

The licensee failed to ensure that the staff and others involved in the different aspects of the resident's bowel care collaborated with each other.

Rationale and Summary

A complaint was received by the Director related to the continence care provided to the resident.

A review of the resident's health records revealed the need for a specific continence care intervention recommended by the hospital team members.

A Registered Nurse (RN) from the NLOT program assessed the resident once or twice a week since the resident was discharged from the hospital. The RN assessments during each visit indicated that the continence care intervention effectively relieved the resident's discomfort.

The resident's written plan of care for continence care included that they may receive a continence care intervention by the NLOT nurses. The care plan did not specify the frequency of this intervention, and there were no orders from the home's physicians related to the intervention.

On an identified date, the resident had a specific health condition in which there were no assessments to capture it. It was not until a later time that another registered nursing staff assessed the resident's health condition and administered an intervention.

A review of the email correspondence between the NLOT program director from Mackenzie Health and the home's leadership team indicated that the NP recommended that the specified continence care intervention for the resident be implemented twice a week, with the possibility of increased frequency. The NP expressed an intention to teach the nurses at the LTCH on several occasions to safely perform the procedure as part of the resident's routine care.

The NLOT Director e-mailed the ED and Sienna's Vice President of Regional Operations (VPRO) on several dates expressing concerns that relying solely on the NLOT nurse for the specified continence care intervention was not sustainable. The ED and VPRO acknowledged the emails, but no response was provided.

On a specified date, the inspector spoke with the VPRO, who did not provide a clear answer regarding the resident's continence care intervention recommended by the hospital.

The RN and Nurse Practitioner (NP) from the NLOT program indicated that the resident may require a specific continence care intervention more than once a week. The NP further indicated that more frequent implementation of the specified intervention may minimize the risk of harm to the resident, promote comfort, and prevent transfer to the hospital.

Both the Medical Director and ED stated that they were not involved in the assessment and implementation of the continence care intervention recommended by the hospital for the resident. The Medical Director was unaware of the frequency of the intervention and did not place an order, as Sienna did not have policies to support the implementation of this intervention in the home. Sienna's VPRO provided no additional information regarding the hospital's intervention or alternate care.

Failure to ensure collaboration between the hospital team members and home staff in the assessment, development, and implementation of continence care interventions placed the resident at risk of exacerbating their medical condition, discomfort, and preventable transfer to the hospital.

Sources: A resident's health records, email correspondence among RN, NP, and NLOT Program Director and the home's ED, DOC, and VPRO, interviews with RN, NP, NLOT Program Director, ED, DOC, Medical Director, and Sienna VPRO.

This order must be complied with by September 13, 2024

COMPLIANCE ORDER CO #002 Dealing with complaints

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must;

A. The DOC, ED, and, in collaboration with the corporate clinical care partner, will develop and implement a process for maintaining a documented record of written and verbal complaints as per legislative requirements.

B. The documented records must include:

(1) the nature of each verbal or written complaint;
(2) the date the complaint was received;
(3) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken, and any follow-up action required;
(4) the final resolution, if any;
(5) every date on which any response was provided to the complainant and a description of the response; and
(6) any response made in turn by the complainant.

C. The corporate clinical care partner shall provide on-site education with the leadership management team, including all department heads, on the complaint process within the home. This should include maintaining and dealing with complaints, the home's complaints management program policy and procedures, and legislative requirements.

D. Keep a record of the training, including the participants, dates, and content of the training sessions.

Grounds

The licensee has failed to ensure that a documented record is kept in the home for any complaint reported by the resident's SDM.

Rationale and Summary

A complaint was received by the Director related to the care provided to the resident.

A review of the email correspondence between the SDM and the home's leadership team revealed that complaints about the resident's care were not documented or included in the home's Complaint Management Binder. When the inspector asked for the home's complaint records, the DOC and ED were unable to produce them.

The home's Complaints Management Program Policy indicates that for any written or verbal complaints that are not resolved in 24 hours, the ED or designate will conduct and document an internal investigation using the Complaint Record Form.

Additionally, the team members will document the nature of the written complaint, the date the complaint was received, type of action taken to resolve the complaint, including the date of action, time frames for actions, any follow-up required, final resolutions, and every date on which any response was provided to the complainant and description of response. All written complaints must be filed in the Complaint Manager Binder.

The ED and DOC confirmed that the SDM's complaints were not documented and filed in the complaint manager binder. The home's complaints program was not followed.

Failure to document written complaints from SDM in the home's complaint record binder regarding the resident's care keeps the concerns untracked and unresolved.

Sources: Home's Complaint Management Program, email correspondence from SDM, DOC, and ED, interviews with ED and DOC.

This order must be complied with by September 13, 2024

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

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.