Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: January 13, 2025
Inspection Number: 2025-1391-0001
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): January 6 -10, 13, 2025
The inspection occurred offsite on the following date(s): January 13, 2025

The following intake(s) were inspected:

- Intake related to Improper/incompetent care of a resident
- Intakes related to resident falls with injury
- First Follow Up – CO #001/ 2024-1391-0005, related to FLTCA, 2021 - s. 24 (1) Duty to Protect, with Compliance Due Date (CDD) of January 3, 2025
- First Follow-up – CO #002/ 2024-1391-0005, related to O. Reg. 246/22 - s. 102 (9) (a), Infection Prevention and Control, with CDD of January 3, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1391-0005 related to FLTCA, 2021, s. 24 (1)

Order #002 from Inspection #2024-1391-0005 related to O. Reg. 246/22, s. 102 (9) (a)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure- licensee

NC #001 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 ensure that a written complaint regarding resident #002's care was immediately forwarded to the Director. The home received the complaint regarding resident #002's care concerns through electronic mail (e-mail), which was not forwarded to the Director until several days later.

Sources: CI report and interview with Director of Care (DOC). [000744]