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

Public Report

Report Issue Date: October 15, 2025

Inspection Number: 2025-1391-0004

Inspection Type:
Complaint
Critical Incident

Licensee: 2063414 Investment LP, by its general partner, 2063414 Ontario Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1, 2, 3, 6, 7, 8, 9, 14, 15, 2025

The following intake(s) were inspected:

- One intake related to an ARI - COVID Outbreak,
- One intake related to a complaint regarding lack of response to Residents' Council concerns, and
- One intake related to physical abuse towards a resident from staff.

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

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that within 10 days of receiving advice, they responded to the Residents' Council in writing.

The Director received a complaint that indicated the Residents' Council had submitted two concerns to the licensee and had not received a response within 10 days.

A record review indicated that two concerns had been submitted to the licensee from the Residents' Council. Upon review, there was no evidence to support the concerns had been responded to within 10 days.

During an interview with the Executive Director (ED), they were unable to locate the responses to the other concern.

Sources: Record review of Residents' Council minutes, interviews with the complainant, and ED.

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, as a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, specifically, resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

The Inspector and a Personal Support Worker (PSW) entered a tub room to find the cleaning brush laying on the floor and no disinfectant available. The PSW went into the shower room to find another container which they brought to the Inspector. Upon review, the container was empty and was labelled "Wipe-Away" which was a solution to remove hard water stains and was not a disinfectant.

The Infection Prevention and Control (IPAC) lead indicated that staff were required to disinfect all shared equipment such as lift chairs, tub and shower chairs with Oxivir Tb Wipes between residents, however the sign posted in the tub room

instructed staff to use the "Wipe-Away" product.

Sources: Observations of tub and shower room, Cleaning and Disinfection signs, interviews with the complainant, PSW and IPAC Lead.

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that an identified resident was protected from physical abuse by a staff member.
The Ontario Regulation 246/22 defined physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.
A resident indicated that during meal service, a staff member attempted to move the dining table towards them to allow another resident to leave the dining table. During this attempt, the table was pushed into the resident and was causing pain. The resident moved the table back to its original position, which began a push and pull of the table three times between the resident and the staff member. The last push from the staff member caused the resident and the dining chair to fall backwards to the floor which resulted in an upper body injury.

The Director of Care (DOC) indicated that the staff member had been removed from the home for physical abuse towards the resident.

Sources: Prevention of Abuse and Neglect of a resident, Policy VII-G-10.00, last

revised 11/2024, resident's clinical records, internal investigation records, video surveillance of incident, interviews with the resident and DOC.

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