Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2017	2017_626501_0017	021336-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Langstaff Square Care Community
170 Red Maple Road RICHMOND HILL ON L4B 4T8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501), DEREGE GEDA (645), NICOLE RANGER (189), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 6, 7, 8, 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22, 2017.

The following critical incidents were inspected during this inspection:
#006856-17 related to the prevention of abuse and neglect and responsive behaviours
#023721-16 related to transferring and positioning technique
The following complaints were inspected during this inspection:
#006544-17 related to food quality
#013398-17 related to the prevention of abuse and neglect and nursing and personal support services
Follow up #004580-17 related to the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Directors of Care (ADOC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Resident Relations Co-ordinator, Personal Support Workers (PSW), Activation Manager, Housekeeping Manager, Housekeeper, Registered Dietitian, Director of Dietary Services, Food Service Supervisor, Dietary Aides, residents, Substitute Decision Makers (SDM), and family members.

During the course of the inspection the inspectors observed the provision of care, resident to resident interactions, staff to resident interactions, reviewed medical records, video surveillance, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_405189_0020	189

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The home has failed to ensure that the home was a safe and secure environment for its residents.

Resident #011 triggered from stage one of the RQI for having had a fall. According to a falls incident progress note, resident #011 fell on an identified date, as he/she was trying to sit on an identified piece of care equipment in an identified unit dining room.

The inspector observed on the same unit that resident #041 was in the dining room at an identified time. There were no lights on in the dining room, the floor was wet and there were identified pieces of care equipment left accessible in the room. The inspector noted that the door which the resident had exited was unlocked. An interview with PSW #113 revealed that this door should be locked as it poses a danger to residents since the floor is wet and identified pieces of care equipment are not safe for residents to sit on.

An interview with RPN #106 revealed the doors to the dining room should be kept locked because it is unsafe for residents to have unsupervised access to identified pieces of care equipment. An observation immediately following this interview revealed both entrances to the unit dining room were unlocked, identified pieces of care equipment were in the middle of the dining room and the floor was wet. The inspector brought this to the RPN's attention who immediately locked the doors.

Further observation revealed that one of the dining room doors on a second unit was unlocked on the same day. The inspector observed that there was also the same type of care equipment located just outside the dining room in the hallway under a Point of Care (POC) computer monitor. An interview with RPN #127 revealed that the dining room door should be locked to prevent residents from going in and having a fall when the floor is wet and identified pieces of care equipment should not be left outside the dining room because residents could sit on them and fall.

Further observation revealed that one of the dining room doors on a third unit was wide open on the same day. As well, an identified piece of care equipment was left unattended in the hallway under a POC monitor. Interviews with RPN #126 and PSW #104 revealed that the dining room door should be locked and identified pieces of care equipment should not be left in the hallway.

An interview with the physiotherapist (PT) revealed the above mentioned pieces of care equipment are unsafe if they are not monitored and should be stored in a place that is inaccessible to residents as they pose a fall hazard.

An interview with the Executive Director (ED) confirmed that the home failed to ensure that the home is a safe and secure environment for its residents as leaving dining room doors unlocked with wet floors and identified pieces of care equipment unattended posed a fall hazard. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The home has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

Resident #007 triggered from stage one of the RQI from the Minimum Data Set (MDS) for continence decline.

Review of resident #007's current written plan of care states the resident may use the washroom and staff should assist him/her to use the washroom. An interview with PSW #108 revealed the resident had a fall months ago and has not walked since. In an interview RPN #111 stated that the plan of care was not updated to reflect resident #007's changes.

An interview with ADOC #129 revealed that when resident #007's continence status changed, the staff completing the assessment should have updated the plan of care. The ADOC confirmed that the home failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. Resident #010 triggered from stage one of the RQI from the Minimum Data Set (MDS) for continence decline.

Review of resident #010's current written plan of care states the resident at times will call for assistance. Interview with PSW #121 revealed resident #010 does not call for assistance. An interview with RPN #126 revealed he/she became aware that resident #010's plan of care was not updated after the inspector spoke with PSW #121 and updated it to reflect that the resident does not call for assistance. The RPN stated the plan of care should have been updated two to three months ago.

An interview with ADOC #129 revealed that when resident #010's continence status changed, the staff completing the assessment should have updated the plan of care. The ADOC confirmed that the home failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

3. During stage one resident interview, resident #008 triggered for no oral hygiene assistance.

A review of resident #008's current written plan of care did not show a focus related to dental and oral status, including oral hygiene. Interviews conducted with Personal Support Worker (PSW) #125, #130, and Registered Nurse (RN) #123 indicated each resident is to have an individualized written plan of care which the PSWs and registered staff have access to through Point Click Care (PCC) and Point of Care (POC). The PSWs and RN staff indicated oral status of a resident is to be a part of the written plan of care as it is important to know what care the resident requires so all staff would be aware of the resident's Assisted Daily Living (ADL) needs. The PSWs and RN reviewed the current written plan of care for resident #008 and confirmed that the written plan of care

did not consist of information related to his/her oral status and oral care needs.

An interview with the Director of Care (DOC) indicated that in each resident's written plan of care, oral status is to be included so that staff providing care will have direction as to what oral care the resident requires. The DOC reviewed the written plan of care for resident #008 and acknowledged that it did not address the resident's oral status, including oral hygiene. [s. 6. (1) (c)]

4. A review of Critical Incident Report submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated resident #030 pushed resident #031 causing a fall. Resident #031 sustained an identified injury.

A record review of progress notes indicated resident #030 has a long history of responsive behaviours and was being followed by a Behaviour Support Services (BSS) team. The BSS team assessment and behavioural support plan of an identified date, outlined recommendations and interventions to support staff members when resident #030 exhibited responsive behaviours. The BSS team identified triggers of responsive behaviours towards care givers and other residents and made recommendations.

A record review of the plan of care effective prior to the above mentioned incident outlined interventions to reduce responsive behaviours towards staff members based on the BSS team recommendations. However, responsive behaviours towards other residents and the recommended interventions were not part of the written plan of care. The home included resident to resident responsive behaviour interventions after the above mentioned resident to resident abuse incident.

An interview with BSS staff #137 confirmed that the plan of care of an identified date did not include the recommendations and interventions outlined by the BSS team for resident to resident responsive behaviours. Staff #137 confirmed that resident #030 has responsive behaviours towards both staff and other residents.

An interview with the Director of Care (DOC) confirmed that the written plan of care prior to the above mentioned incident did not include interventions for responsive behaviours towards other residents. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by resident #030.

A review of a Critical Incident Report submitted to the Ministry of Health and Long Term Care (MOHLTC) indicated resident #030 exhibited an identified responsive behaviour toward resident #031causing a fall. Resident #031 sustained an identified injury.

A record review of progress notes indicated resident #030 has a long history of responsive behaviours and was being followed by a Behaviour Support Services (BSS) team. The BSS team assessment and behavioural support plan of an identified date, outlined recommendations and interventions to support staff and protect other residents from abuse when resident #030 exhibits responsive behaviors.

A record review of the written plan of care, effective prior to the above mentioned incident did not include the recommendations and interventions made by the BSS team to protect other residents when resident #030 exhibits responsive behaviours. The plan included resident to resident responsive behaviour interventions after the resident to resident abuse incident.

An interview with BSS staff #137 confirmed that the plan of care of an identified date did not include the recommendations and interventions made by the BSS team to protect other residents from abuse. BSS staff #137 confirmed that resident #030 had responsive behaviours towards both staff and other residents. Staff #137 reiterated that the plan of care should have interventions related to resident to resident behaviours. As a result, he/she confirmed that the above mentioned incident could potentially have been prevented.

An interview with the Director of Care (DOC) confirmed that the plan of care prior to the above mentioned incident did not include interventions for responsive behaviors towards other residents. The goal of the BSS recommendation was to protect other residents from abuse. The interventions and recommendations made by the BSS team were not in the plan of care and not implemented. Hence, residents were not protected from abuse and the above mentioned incident could have been prevented. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by resident #030, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the evening meal was not served before 1700 hours.

Observation on September 19, 2017, revealed that residents in an identified unit dining room had all been served their evening meal at 1658 hours and the staff were preparing to serve dessert. Interview with Dietary Aide #136 revealed he/she started serving the meal at 1650 hours. Interview with RPN #135 revealed he/she was unaware of the legislation requiring the evening meal not be served before 1700 hours.

Observation of video surveillance for the evening meal in the identified unit dining room on September 19, 2017, revealed beverages were being served at 1640 hours and meals were being served at 1650 hours.

Interview with the DOC revealed he/she was unaware this was occurring. The DOC and inspector viewed video surveillance of the evening meal in the above mentioned dining room which were consistent with the inspector's observation on September 19, 2017. The evening meal service was being served as follows:
• September 18, 2017 at 1639 hours
• September 17, 2017 at 1640 hours
• September 16, 2017 at 1640 hours
• September 15, 2017 at 1640 hours
• September 14, 2017 at 1640 hours
• September 13, 2017 at 1640 hours
• September 12, 2017 at 1639 hours

The DOC and Director of Dietary Services (DDS) confirmed that the evening meal in the identified unit dining room was being served before 1700 hours. [s. 71. (6)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the evening meal is not served before 1700 hours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During the initial tour of the home conducted on September 6, 2017, at 0944 hours on an identified unit the inspector found a door labelled "E Housekeeping", to be unlocked. The door was equipped with a gray metal number lock to gain access to the room. When the door handle was pulled the door opened and when the door was let go, the door would close but not lock. The inspector observed Personal Support Worker (PSW) #100 up the hall four doors down who observed the inspector and came over.

An interview with PSW #100 confirmed the door labelled "E Housekeeping", was unlocked and indicated the door is to be locked at all times as the room is for the cleaning staff only. The PSW and inspector were entering the room as resident #024 attempted to enter the room and was stopped by the PSW who indicated the room is a risk as the home area was the secure unit and residents wander. The PSW went into the housekeeping room with inspector and confirmed the following items where in the room:
-Chemical dispenser attached to Disinfectant, Glass Cleaner, and Neutra Floor Cleaner each in a 20 liter (L) white container to a black hose running out to the dispenser hose
-Eye wash station attached to the tap
-Six bottles of Purell hand sanitizer

Registered Practical Nurse (RPN) #101 arrived, confirmed the "E Housekeeping" door was unlocked and indicated the room is used by housekeeping staff and is not a designated area for residents. The RPN further indicated he/she is part-time and unsure if the door is to be locked or left unlocked. The RPN indicated the room consisted of chemicals and it posed a risk to residents as this home area was the locked unit. The RPN indicated the housekeeper and the supervisor were on the floor and proceeded to get the housekeeper.

An interview with Housekeeper #102 indicated he/she is the full-time housekeeper on the unit and the "E Housekeeping" door is to be locked at all times and if a resident gets into the room the resident has access to chemicals. The Housekeeper indicated he/she is aware that the identified door lock gets jammed from the inside and does not lock. The Housekeeper then turned the lock from the inside and the door locked.

An interview with Housekeeping Supervisor #103, confirmed the above observations in room "E Housekeeping" as he/she arrived with the Housekeeper and indicated the door is to be locked at all times as it posed a risk to wandering residents. The Supervisor indicated he/she would ensure maintenance fixes the door immediately and proceeded to lock the door from inside. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home where labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff.

Resident #003 triggered from stage one of the RQI for having had a fall. During the course of the inspection resident #003 was found to have an order for an identified type of restraint.

A review of resident #003's current written plan of care indicated staff were to ensure an identified type of restraint is engaged while resident #003 is in his/her wheelchair and safety checks were to be carried out hourly while the restraint was applied.

The inspector carried out multiple observations during the course of the inspection and on an identified date, observed resident #003 to be sitting asleep holding the identified restraint. The inspector observed the restraint was not engaged. The inspector called RPN #122 who was able to engage the restraint. The RPN confirmed the restraint was not engaged and the PSW staff are to monitor the resident hourly for safety checks.

In an interview PSW #143 acknowledged that resident #003 has an identified type of restraint which is to be checked hourly and documented in Point of Care (POC). The PSW indicated he/she does not recall if he/she applied the restraint on resident #003 this morning and confirmed he/she did not carry out hourly safety checks on resident #003. The PSW indicated he/she was unaware the restraint was broken. The PSW indicated that hourly checks on the resident's restraint were not carried out as per the written plan of care.

An interview was conducted with RN #122 who indicated resident #003 has an identified type of restraint and the PSW staff are to carry out hourly safety checks on the restraint. The RN acknowledged that he/she was unaware that resident #003's restraint was broken and not applied correctly and also indicated that hourly safety check were not carried out as per POC documentation.

An interview with RPN #123 confirmed resident #003 has a restraint which is to be monitored hourly by the PSW staff. The RPN reviewed the POC documentation for safety checks hourly while the restraint is applied and confirmed that hourly restraint checks were not carried out consistently by the PSW staff on all shifts.

An interview with the DOC indicated the home's expectation and policy was that when a resident has a restraint, the PSW staff are to monitor the restraint hourly and document in POC. The DOC indicated resident #003 has a restraint and after reviewing the POC documentation acknowledged there was no evidence in POC documentation to indicate

that hourly safety checks were carried out consistently for the dates indicated for resident #003. [s. 110. (2) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is monitored at least every hour while restrained by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff, to be implemented voluntarily.

Issued on this 18th day of October, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.