Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2019	2019_685648_0020	013330-19, 014897-19, 014898-19, 017593-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

JOVAIRIA AWAN (648), ANGIEM KING (644)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 10, 11, 15, 16, 17, 18, 21, 22, and 23, 2019.

During the course of this inspection, the following Critical Incident System (CIS) reports were inspected upon:
Log #013330-19, related to a resident fall,
Log #017593-19, related to a resident fall,
Log #014897-19, for Compliance Order #001 related to r. 8. (1) issued under inspection #2019_263524_0022 with a compliance due date of August 30, 2019,
Log #014898-19, for Compliance Order #002 related to s. 50 (2) issued under inspection #2019_263254_0022 with a compliance due date of August 30, 2019.

During the course of the inspection, the inspectors completed observations of meal and snack service, staff and resident interactions and the provision of care, record review of health records, staffing schedules, home's investigation records, the homes complaints records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Resident Relations Coordinator (RRC), Activation Aide (AA), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers
(PSWs), Physiotherapist (PT), Occupational Therapist (OT), Receptionist, and Substitute Decision Makers (SDM's).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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
O.Reg 79/10 s. 50. (2)	CO #002	2019_263524_0022	644
O.Reg 79/10 s. 8. (1)	CO #001	2019_263524_0022	648

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other 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 Ministry of Long Term Care (MLTC) received a Critical Incident System (CIS) report on an identified date indicating resident #002 had sustained a fall with injury and subsequent hospitalization. Resident #002 was found in an identified home area with an apparent injury on the date of the incident. The resident reported that they had attempted to self transfer resulting in the fall. Resident #002 was transferred to hospital and returned the same day to the home with a diagnosis of and treatment for an identified injury.

Following return from hospital, resident #002's records identified physiotherapy (PT) assessed the resident on the same day. The assessment identified resident #002 to have a decline in their mobility status. The assessment identified that the resident required a change in the manner in which they were to be transferred and provided care by front line staff. A subsequent assessment completed at a later date, iterated resident #002's change in mobility status related to the fall.

Review of resident #002's written plan of care at the time of this inspection, identified the resident to be mildely confused, and identified a specified level of mobility for transfers and care.

Interviews conducted during the inspection with PSW #100 and PSW #133 identified as resident #002's regular care givers, reported that they were familiar with resident #002

and that the resident had declined since their fall and hospitalization. PSW's #100 and 133 revealed that the resident required care and transfer assistance in an identified manner. Resident #002's written plan of care was reviewed during the interviews with PSW's #100 and #133. They confirmed the written plan of care did not reflect the manner in which resident #002 currently received care. PSW #100 stated they were not informed or aware of PT's assessment directing staff the change in resident #002's mobility and manner in which to provide transfers and care, and confirmed they did not provide care according to this assessment. PSW #133 did not demonstrate awareness of the residents assessed level of transfer and care assistance during the interview.

Interview with RPN #125 identified resident #002 was at an identified risk of falls. RPN #125 stated that changes in resident care following interdisciplinary assessment were to be communicated to nursing staff, and subsequently updated in the written plan of care to provide clear direction to guide direct care staff in the provision of care to residents in the home, and that each shift would report to the next to ensure updates are communicated. RPN #125 reported resident #002 was cognitively impaired and required a specified manner in which they were to be transferred and provided care. RPN #125 reported resident #002 had a decline in their mobility following the fall, and would be unsafe to ambulate and transfer as they did before due to their identified injury. Resident #002's written plan of care and physiotherapy assessment was reviewed with the RPN #125. RPN #125 confirmed the care plan which PSW staff would refer to for direction on resident #002's care, was not based on the the residents assessment by physiotherapy and had not been updated accordingly. RPN #125 reported they were not aware of the residents assessed by PT at the time of the interview.

Interview with PT #102 identified that a residents written plan of care was to be updated following an assessment by the PT which would be verbally communicated to the nursing department in order to provide clear direction to staff for the residents assessed needs. Staff interviews related to resident #002 and their written plan of care was reviewed with PT #102. PT#102 confirmed resident #002 had been assessed on the identified date, and determined to require a specified level of assistance due to their change in mobility and identified injury following the fall, and reported that resident #002 was unsafe to ambulate or transfer as reported by PSW staff at the time of the interview with the inspector. PT #102 reported that resident #002 was unable to safely use their personal assistive safety device (PASD) for ambulation, and that all locomotion was to be in another identified PASD until PT reassessed the resident. PT #102 confirmed that the plan of care did not reflect the residents current assessment. and it was unsafe for staff to provide care and transfers in the manner in which they reported. PT #102

acknowledged the current written plan of care did not reflect the residents assessed needs and recommended interventions for mobility and transfers, and it provided unsafe direction to nursing and PSW staff for resident #002 care.

Resident #002's physiotherapy assessments, written plan of care, and staff interviews were reviewed with the homes DOC. The DOC confirmed that when a resident's mobility changes, regardless of the level of change, a referral is required for physiotherapy to assess and advise direct care staff of any changes in the manner in which a resident in the home is provided care, including mobility and transfer assistance. The DOC acknowledged the plan of care for resident #002 did not reflect staff and others involved in the different aspects of care collaborated with each other 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. [s. 6. (4) (b)]

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 that staff and others involved in the different aspects of care collaborate with each other 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,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The license failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure it is complied with.

According to O. Reg 79/10 s. 48 (1) 1. Every licensee of a long-term care home shall ensure an interdisciplinary falls prevention and management program is to be developed and implemented in the home.

The MLTC received a CIS report on an indentified date indicating resident #001 to have had an fall in a specified area of the home. The CIS indicated resident #001 was monitored by staff following the fall and subsequently transferred to hospital following assessment by staff later on the same day. The CIS report identified that a Physician or Nurse Practioner was not called.

Review of the homes policy "Head Injury Routine" (Policy #VII-G-30.20, April 2019) identified that a an HIR will be initiated following a head injury or possible injury and that the nurse would notify the physician and the Power of Attorney (POA)/Substitute Decision Maker (SDM) of the incident that caused the actual or possible injury to the resident. Review of the homes policy "Falls Prevention and Management" (VII-G-30.10, April 2019) identified that when a fall occurs, the nurse will ensure the resident is not moved if there is suspicion or evidence of injury, and that the physician should be contacted.

Review of resident #001's health records identified a progress notes documented on the date of the incident by RPN #125 identified resident #001 sustained a fall in home area at a specified time. Resident #001 was found in the home area with an identified injury. A progress noted documented RPN #125 on the date of the incident at a later time identified resident #001 was identified to have deteriorated and a nursing assessment was completed at this time. Resident #001 was subsequently sent to hospital after an identified time following the initial fall on the same day.

Review of resident #001's Head Injury Routine (HIR) initiated following the fall identified assessment date reflecting the residents change over the period of time they were monitored in the home following the fall until they were transferred to hospital on the same day.

Interview with RPN #125 identified they responded to resident #001's fall and found them in the identified home area with an apparent injury related to the fall. RPN #125 reported they treated the injury and continued to monitor the resident until they were sent to hospital later that day. RPN #125 confirmed they did not notify the physician of resident #001's fall at the time.

Interview with the homes DOC identified that if a resident sustains an injury following a fall, which requires further assessment, it would require the physician to be notified. The DOC stated if the staff noted an apparent injury and nursing assessment indicated a deterioration, the physician is to be notified by nursing staff. Review of resident #001's health records, and staff interviews were reviewed with the DOC. The DOC stated that based on the change in the residents status documented in the HIR the residents physician should have been notified as the resident was not sent to hospital until a later time in the day after the apparent injury had been initially identified at the time of the fall. The DOC confirmed that the homes policy for Falls prevention and management and Head Injury Routine were not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure it is complied with,, to be implemented voluntarily.

Issued on this 31st day of October, 2019

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

Original report signed by the inspector.