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 30, 2019	2019_807644_0014	012991-19, 015214-19, 016562-19, 018392-19	Complaint

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

ANGIEM KING (644), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

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

During this inspection the following complaints were inspected:
-Log #012991-19 related to Recreation and Social Activities, and Personal Support Services,
-Log #015214-19 related to Personal Support Services,
-Log #016562-19 related to Personal Support Services, Snack Observation,
-Log #018392-19 related to Dignity, Choice and Privacy, Pain, and Personal Support Services.

During this inspection the following inspections were conducted concurrently:
Critical Incident Report #2019_685648_0020.

During the course of the inspection, the inspector(s) completed observations of snack service, staff and resident interactions and the provision of care, record review of health records, staffing schedules, home's investigation 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:
Dignity, Choice and Privacy
Pain
Personal Support Services
Recreation and Social Activities
Snack Observation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified.

The Ministry of Long Term Care (MLTC) received complaint regarding a written complaint submitted to the home on an identified date, by resident #003's substitute decision maker (SDM). The written complaint identified multiple areas of concerns by resident #003's SDM related to their care, including provision of identified Activity of Daily Living (ADL) from specific personal support worker (PSW), despite the resident's requirement for a specific PSW.

Interview with resident #003's SDM identified the resident required a specific PSW to provide identified Activity of Daily Living (ADL). The SDM stated that a specific PSW continued to provide resident #003 identified ADLs despite this expressed preference which had been communicated to the home at the time of the written complaint.

Review of resident #003's written plan of care identified the resident required extensive to total assistance with two staff for identified ADLs. The care plan identified ADLs was to be provided by specific caregivers only due to the resident's preferences as of a specified date.

Review of resident #003's health record reviewed from specified dates, identified multiple PSW staff had provided identified care to resident #003 during specific shifts. Of this review, PSW #109 was identified to have provided the identified care most often to the resident, on 50 instances during the specified shift.

Interview with identified PSW #109 stated that they were directed to provide care to residents with expressed preferences for specific PSWs during the identified shift in the absence of the specific staff. PSW #109 stated specific PSW staff were not re-assigned

to resident #003's unit during the identified shifts from other home areas when specific PSWs were assigned on their shift prior to this interview.

Interview with the homes Director of Care (DOC) identified that it was mandatory for all direct care staff to provide care to residents in the home as per their plan of care. The DOC stated staff who provide care to a resident, are expected to document the care they had provided. The DOC acknowledged resident #003 was very conservative and private and required specific PSW staff for specific ADL care, as noted in their plan of care dated from a specified date, following discussion with the SDM when the written complaint was received by the home on a specified date. The DOC reviewed resident #003's care records identifying multiple specific PSWs had provided the resident identified care during specific shifts for the period reviewed, including PSW #109. The DOC acknowledged that resident #003's care was not provided as specified in their plan as a specific PSW staff had provided care to the resident. [s. 6. (7)]

2. Due to non compliance identified related to resident #003, resident #006 was inspected upon for provision of care as specified in the plan.

Review of the home's Complaints Binder identified the home's written documentation demonstrating they were made aware of a complaint made by resident #006's family member on a specified date. The complaint indicated that the home was informed at the most recent family meeting with the home of resident #006's preferences for a specific PSW for specific ADLs. The complainant identified that the resident was provided identified care including a specific ADL from a specific PSW staff which had upset the family and the resident. The home's complaint records demonstrated that resident #006 had been provided identified care from a specific PSW at the time of this complaint.

Review of resident's progress note on a specified date, documented by RN #110 identified the resident's family member had expressed that resident #006 was to receive specific care from specific staff only.

Review of resident #006's written plan of care identified the resident required two staff assistance for repositioning and identified ADLs. The plan of care further identified specific PSW for identified ADLs and the resident's wish to have specific staff to provide identified ADLs, which was updated into the residents written plan of care on a specified date.

Review of resident #006's provision of care documentation identified PSW #114 often provided care to the resident during the identified shift. PSW #114 was identified as one of two PSWs assigned to the resident's home area on 19 identified shifts on identified dates, according to the homes staffing records. Review of POC documentation identified resident #006 received identified ADL on two instances from specific PSW staff, and 12 additional instances of specific PSW staff providing identified ADL care during the identified dates.

Interview with PSW #114 reported resident #006 required two staff assistance for identified care and reported they were aware of resident #006's preference for specific PSWs. PSW #114 stated they continued to provide the identified care to the resident with specific PSW staff assistance during the identified shift after becoming aware of the preference and at times with only specific staff assisting if no specific PSWs were scheduled with them. PSW #114 reported nursing did not provide assistance during the identified care provision to resident #006 and stated that specific staff were not made available to switch with them from other home areas when resident #006's home area was scheduled specific PSWs only in order to provide the identified care.

Resident #006's plan of care, POC documentation, complaints record, and staff interviews were reviewed with the home's DOC during an interview. The DOC acknowledged that resident #006 required two staff assistance for identified ADLs, and that specific PSW staff continued to provide resident #006 identified care. The DOC acknowledged resident #006 was not provided care as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 1st day of November, 2019

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

Original report signed by the inspector.