Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
Aug 11, 2020	2020_748653_0015	001933-20, 002089-20, 002412-20, 006614-20, 007729-20, 008253-20	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

ROMELA VILLASPIR (653)

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): July 22, 23, 24, 27, 28, 29, 2020.

During the course of the inspection, the following intakes were inspected:

Critical Incident System (CIS) intakes related to falls with injuries: -001933-20, 002089-20, 006614-20, 007729-20;

-008253-20 related to allegation of staff to resident abuse.

Follow-Up #002412-20, CO #001 issued on January 28, 2020, within report #2020_595110_0001, related to Ontario Regulation 79/10, s. 69.

During the course of the inspection, the inspector observed the residents, provision of care, reviewed clinical health records, the home's investigation notes, relevant home policies and procedures, and documentations related to the compliance order.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, Physiotherapist (PT), Associate Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

- **3 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. 69.	CO #001	2020_595110_0001	653

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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #003 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The home submitted a Critical Incident Report (CIR) to the Director for an incident that caused an injury to resident #003 for which the resident was taken to hospital, and which resulted in a significant change in the resident's health status. The CIR indicated that the resident had an unwitnessed fall in their bedroom, and was sent to hospital for further assessment.

A review of resident #003's falls history indicated they had previous falls in the most recent quarter prior to the critical incident fall.

A review of the Physiotherapist (PT)'s progress notes indicated they recommended a falls prevention intervention for resident #003, following the previous falls.

A review of the history of resident #003's falls interventions did not indicate that the PT's recommendation was added to their plan of care.

Separate interviews with the Personal Support Workers (PSWs) and the Registered Staff indicated they do not recall seeing the PT's recommended falls prevention intervention, in the resident's room.

An interview with the PT indicated they could not recall if their recommended falls prevention intervention was put in place for resident #003.

During an interview, ADOC #113 who was the lead of the home's falls prevention program, reviewed resident #003's written plan of care and the support actions on Point Click Care (PCC), and acknowledged that the PT's recommended falls prevention intervention was not added to the plan of care, and therefore, was not put in place. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #003's written plan of care was provided to the resident as specified in the plan.

A review of resident #003's written plan of care indicated they were at risk for falls, and they were to have falls prevention interventions in place.

During an observation, the inspector noted that two of resident #003's falls prevention interventions were not in place, which was acknowledged by Registered Practical Nurse (RPN) #100.

During an interview, the inspector informed the Executive Director (ED) of the above mentioned observation, and the ED acknowledged that care was not provided to resident #003 as specified in the plan as it related to their falls prevention interventions. [s. 6. (7)]

3. The licensee has failed to ensure that resident #003 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

A review of resident #003's falls history indicated they had previous falls in the most recent quarter prior to the critical incident fall.

A review of the history of resident #003's falls interventions did not indicate that new falls

interventions were added to the plan of care following the previous falls.

During an interview, ADOC #113 who was the lead of the home's falls prevention program, reviewed resident #003's written plan of care and acknowledged that no new interventions were added following the previous falls. The ADOC further indicated that the expectation was to look at different falls interventions for the resident.

During an interview, the Director of Care (DOC) indicated that after each fall, the staff were to review the current falls interventions, and the plan of care would be updated. The DOC stated the registered staff and falls lead would be responsible for the review and revision of the plan of care, when the care set out in the plan was no longer effective, as it related to falls interventions. [s. 6. (10) (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 staff and others involved in the different aspects of care of the resident 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 care set out in the plan of care is provided to the resident as specified in the plan;
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A review of the Nurse Practitioner (NP)'s progress note, indicated resident #003's medical diagnoses from the hospital, following their unwitnessed fall in the home.

An interview with RPN #109 indicated upon re-admission of a resident from the hospital back into the home, and if the resident had an identified injury, it would be the PT who would re-assess the resident's transfer status. RPN #109 stated they would leave the resident in bed and make sure they were comfortable, until the PT's reassessment.

A review of resident #003's Activities of Daily Living (ADL) – Toileting history indicated the approaches/ support actions were updated by RPN #109 upon the resident's re-admission to the home. The update indicated that resident #003 required staff assistance for toileting, due to their recent fall injury.

A review of RPN #100's progress note indicated resident #003 constantly tried to exit from the bed and was seen sitting on the edge of the bed. RPN #100 and the other staff repositioned the resident, and the resident was seen trying to stand but unable to. Staff tried to convince resident #003 to void in their continence product but the resident refused, and kept trying to go to the washroom.

During an interview, RPN #100 indicated at that time, resident #003 just came back from the hospital, had the injury, and they could not take the resident to the toilet. The RPN stated that the staff tried to get resident #003 to use their continence product and the staff would just change the resident after.

An interview with PSW #118 indicated due to the resident's fall injury, the staff provided

resident #003 with continence product and encouraged the resident to void or have a bowel movement in bed and they would just change the resident after. PSW #118 further indicated even with the injury, resident #003 still wanted to go to the washroom and did not want to have a bowel movement in their continence product.

During an interview, the DOC reviewed RPN #100's progress note and acknowledged the inspector's staff interviews which indicated that resident #003 was encouraged to void and have a bowel movement in their continence product. The DOC stated it was not acceptable, and that the staff could have offered an alternative to the resident until the PT re-assessed the resident's transfer status.

The licensee has failed to ensure that resident #003 who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence. [s. 51. (2) (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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #3: 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 licensee has failed to ensure that any policy instituted or otherwise put in place, was complied with.

According to Ontario Regulation (O. Reg.) 79/10, s. 49 (2), "Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls".

A review of the home's policy titled "Falls Prevention & Management" #VII-G-30.10 revised in February 2020, indicated under procedure that the nurse will complete a post falls assessment and head injury assessment as required. The initial post-fall assessment note must include the following:
-assessment of damage to the hip joint i.e. extreme pain, shortened and/ or abduction of the externally rotated leg, inability to weight bear;
-limited range of motion of joints.

The home submitted a CIR to the Director, for an incident that caused an injury to resident #002 for which the resident was taken to hospital, and which resulted in a significant change in the resident's health status. The CIR indicated that resident #002 had an unwitnessed fall in their bedroom, and was transferred to hospital for further assessments.

A review of the Risk Management Module (RMM) and post fall incident form did not indicate that the initial post-fall assessment note included the assessment of the injury.

During an interview, RPN #123 indicated post fall, they conducted a head to toe assessment on the resident. During the interview, the RPN reviewed the RMM and post fall incident form they completed, and acknowledged their lack of documentation on the assessment.

During an interview, the DOC reviewed the RMM and post fall incident form and acknowledged that in RPN #123's initial post-fall assessment note, the RPN did not comply with the home's policy on "Falls Prevention & Management". [s. 8. (1) (b)]

Issued on this 12th day of August, 2020

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

Original report signed by the inspector.