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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 19, 2020	2020_823653_0021	022545-20	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): November 17, and 18, 2020.

During the course of the inspection, Critical Incident (CI) Log #022545-20 related to a COVID-19 outbreak, was inspected.

During the course of the inspection, the inspector toured the home, observed the residents, provision of care, and infection prevention and control practices, and reviewed York Region Public Health's inspection report.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Care Support Assistant (CSA), Housekeeper (HK), Infection Prevention and Control (IPAC) Lead, Assistant Director of Care (ADOC), Sienna IPAC Clinical Partner, and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted a Critical Incident Report (CIR) to the Director related to a COVID-19 outbreak in the home.

During the course of the inspection, all residents in the home were isolated and were on droplet and contact precautions. The following observations were conducted in five different home areas:

-Eleven Personal Protective Equipment (PPE) caddies were not fully stocked with the appropriate PPE.
-A clean beige continence brief was placed on top of the disinfectant wipes container, located on top of the PPE caddy outside of a resident's room.
-A Personal Support Worker (PSW) was observed holding on to a reusable gown while walking down the hall, and discarded the gown in a resident's room. The PSW indicated to the inspector that they doffed off the gown in a room they were previously in, and discarded it in the laundry bin in another resident's room.
-A PSW entered and exited five different resident rooms and took out the dirty reusable gowns from each laundry bin with their bare hands. The PSW did not perform hand hygiene nor wear the proper PPE.
-A Registered Practical Nurse (RPN) did not wear the proper PPE when they administered medications to two residents in the room. The RPN also discarded their gloves in their medication cart garbage bin after exiting the room.
-A PSW did not perform hand hygiene prior to donning on their gown and gloves, and entering a resident's room.
-An RPN did not wear the proper PPE when they administered medications to the resident in the room. Afterwards, the RPN pumped Alcohol Based Hand Rub (ABHR) on a piece of Kleenex and wiped down the thermometer they used.
-Two PSWs were observed doing the snack pass and were in and out of three different resident rooms. PSW #103 did not don on gloves nor gown prior to entering each resident room. PSW #104 did not don on a gown prior to entering the rooms, and only donned on one glove after entering the rooms.
-A Care Support Assistant (CSA) did not perform hand hygiene in between resident contact.
-A small purse was placed on top of the PPE caddy outside of a resident's room. A PSW picked up the small purse, walked down the hall, and returned the purse to the resident in a different room. The PSW hung the small purse on the resident’s assistive device without disinfecting the purse.
-A PSW did not perform hand hygiene after doffing off their gloves and gown, and prior to

exiting the room.
-A Housekeeper (HK) donned on a gown and one glove on their right hand prior to entering, and cleaning inside a resident's room. The HK emptied a garbage bin that did not have a plastic bag, and the HK did not clean and disinfect the bin. The HK doffed off their gown in the hallway and was observed applying a new mask while they still had the face shield on.
-A PSW did not adhere to the IPAC practices, specifically proper doffing and disposal of PPE while inside the resident's room.
-A PSW exited the room with their full PPE on, came out the hallway, and pulled the meal service cart closer to the door.
-The inspector noted safety goggles were placed on top of the ABHR dispenser just outside a resident's room.
-A PSW was inside a resident's room, and did not have gloves on while adjusting the chair they were going to sit on, to provide feeding assistance to a resident.
-An RPN did not perform hand hygiene prior to donning on gown and gloves, and discarded the gown into the bin without folding it or rolling it into a bundle.

A review of York Region (YR) Public Health's inspection report dated November 15, 2020, indicated that the home's Executive Director (ED) has not yet implemented all recommendations from prior visit that occurred on November 9, 2020. As per the visit on November 15, 2020, the recommendations included:
-that all PPE caddies are fully stocked at all times, and that all caddies have all appropriate PPE in them (ABHR, gloves, masks, gowns, and disinfection wipes);
-to continue to provide education to staff on hand hygiene, selection and use of PPE, donning/ doffing of PPE, cleaning and disinfection of eye protection.

The YR IPAC specialist indicated that the home required support in the following IPAC areas:
-Education and training on point of care PPE risk assessment; proper selection and use of PPE; proper PPE donning and doffing of PPE; transmission based precautions; Auditing routine practices and PPE compliance; Staff education on environmental cleaning and disinfecting, laundry and waste management, routine practices and hand hygiene, physical distancing and group activities.

The above mentioned observations were shared with the home’s IPAC Lead, ED, and the Sienna IPAC Clinical Partner. The IPAC Lead and the ED acknowledged the inspector’s observations and that the staff did not participate in the implementation of the IPAC program. The risk associated to the staff not adhering to the home’s IPAC program

would be possible transmission of infectious agents during the ongoing COVID-19 outbreak in the home.

Sources: YR Public Health's inspection report dated November 15, 2020; Inspector #653's observations; interviews with the IPAC Lead, ED, and other staff. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 20th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2020_823653_0021
Log No. / No de registre :	022545-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 19, 2020
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Langstaff Square Care Community 170 Red Maple Road, RICHMOND HILL, ON, L4B-4T8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Deniese Johnson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE in them.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted a Critical Incident Report (CIR) to the Director related to a COVID-19 outbreak in the home.

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Sources: YR Public Health's inspection report dated November 15, 2020; Inspector #653's observations; interviews with the IPAC Lead, ED, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because the home was on COVID-19 outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations in five different units, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office