

**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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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 9, 2021	2021_715672_0011	015669-20, 016542-20	Complaint

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**Licensee/Titulaire de permis**

2063414 Ontario Limited as General Partner of 2063414 Investment LP  
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Langstaff Square Care Community  
170 Red Maple Road Richmond Hill ON L4B 4T8

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

JENNIFER BATTEN (672)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): March 18, 19, 22 and 23, 2021**

**The following intakes were completed during this inspection:**

**One intake related to a complaint received regarding medication administration and fall prevention practices occurring in the home.**

**One intake related to a complaint received regarding infection prevention and control and visitation practices occurring in the home.**

**During the course of the inspection, a Critical Incident System inspection was conducted concurrently. During that inspection, the following intakes were completed:**

**One intake related to a resident fall which resulted in an injury.**

**One intake related to an allegation of improper care of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Dietary Manager, IPAC Lead, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeepers, health screeners, maintenance workers and residents.**

**The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control and Falls Prevention. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**

**Infection Prevention and Control**

**Medication**

**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)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**

**(a) drugs are stored in an area or a medication cart,**

**(i) that is used exclusively for drugs and drug-related supplies,**

**(ii) that is secure and locked,**

**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**

**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**

**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

### **Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During an observation, Inspector noted that the home had been keeping medicated treatment creams in resident #012's bedroom.

During separate interviews, PSW #101 and RPN #116 indicated the treatment creams were always stored in resident #012's bedroom for PSW staff to easily access in order to utilize for the resident.

During separate interviews, the DOC and Executive Director indicated medicated treatment creams were always supposed to be stored in the locked medication room when not being used.

Sources: Observations conducted, interviews with PSWs, RPNs, the DOC and Executive Director. [s. 129. (1) (a)]

***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 drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and kept secured and locked, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director which alleged that resident #010 did not receive medications as per the physician's order. Resident #010's POA alleged that due to not receiving the medications according to the physician's order, resident #010 sustained a fall that resulted in an injury.

During record review, Inspector noted that resident #010 sustained a fall. Review of the physician's orders indicated the resident had an order for two identified medications to be administered at specified times. Review of the progress notes and electronic medication administration record (eMAR) indicated that during an identified time frame, resident #010 did not receive their medications an identified number of times.

During separate interviews, the DOC and Executive Director indicated the expectation in the home was for staff to administer all medications as per the physician's orders.

Sources: Resident #010's identified eMAR; progress notes and physician's orders from specified periods of time; interviews with the DOC and Executive Director. [s. 131. (2)]

***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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**Issued on this 9th day of April, 2021**

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

**Original report signed by the inspector.**