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
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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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
Jun 28, 2021	2021_823653_0015	006731-21, 007037-21, 007628-21	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), JACK SHI (760)

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): June 14, 15, 16, 17, 18, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
-Log #(s): 006731-21, 007037-21, and 007628-21, were related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Care Support Assistants (CSAs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Physiotherapist (PT), Housekeepers (HKs), Director of Environmental Services (DES), Assistant Directors of Care (ADOCs), Director of Care (DOC), and the Executive Director (ED).

During the course of the inspection, the inspectors toured the home, observed Infection Prevention and Control (IPAC) practices, provision of care, staff to resident interaction, reviewed clinical health records, staffing schedule, and relevant policies and procedures.

Inspector #694426 was also present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that Registered Practical Nurse (RPN) #110 collaborated with the physician when resident #002 exhibited discomfort following their fall.

The home had submitted a Critical Incident Report (CIR) to the Director related to resident #002's fall, which resulted in an injury. A review of the progress notes indicated that the resident had a fall in their bedroom. Upon Registered Practical Nurse (RPN) #110's post fall assessment, the resident complained of discomfort and stated that they needed to go to the hospital. The following day, RPN #116 called the physician and

received an order for a diagnostic test, which later confirmed the resident's injury, and the resident was subsequently sent to hospital. RPN #110 stated they did not contact the physician on the day that the resident fell. The Director of Care (DOC) stated that as per their internal investigation, they concluded that RPN #110 should have contacted the physician when the resident complained of discomfort post fall. There was potential risk to the resident, as their injury may have been further exacerbated when the RPN failed to take further action by contacting the physician related to their complaint of discomfort post fall.

Sources: Review of resident #002's progress notes and electronic chart; Interviews with RPN #110, the DOC and other staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care as it related to falls interventions, were provided to residents #001, #002, and #003, as specified in the plan.

A review of resident #001's care plan indicated they were at risk for falls, and staff were to implement specific falls prevention interventions.

During an observation conducted by Inspector #653 with PSW #111, and RPN #112, resident #001's falls prevention interventions were not in place.

Separate interviews with RPN #112 and Assistant Director of Care (ADOC) #115 indicated that the risk associated to not implementing the interventions was potential for another fall.

Sources: Review of resident #001's care plan; Inspector #653's observation; Interviews with PSW #111, RPN #112, and ADOC#115. [s. 6. (7)]

3. A review of resident #002's care plan indicated they were at risk for falls, and staff were to implement a specific falls prevention intervention.

During an observation conducted by Inspector #760 with PSW #109, resident #002's falls prevention intervention was not in place. There was potential risk to the resident, as the failure to apply the intervention may result in staff not becoming immediately aware and respond when a resident may become at risk for falling.

Sources: Review of resident #002's care plan; Inspector #760'so observation; Interviews

with PSW #109 and other staff. [s. 6. (7)]

4. A review of resident #003's care plan indicated they were at risk for falls, and staff were to implement specific falls prevention interventions.

During an observation conducted by Inspector #653 with PSW #121, and RPN #119, resident #003's falls prevention interventions were not in place.

Separate interviews with RPN #119 and ADOC #115 indicated that the risk associated to not implementing the interventions was a potential fall.

Sources: Review of resident #003's care plan; Inspector #653's observation; Interviews with PSW #121, RPN #119, and ADOC #115. [s. 6. (7)]

5. The licensee has failed to ensure that resident #003's plan of care was reviewed and revised when their care needs changed.

The home had submitted a CIR to the Director related to resident #003's fall that resulted in an injury.

A review of resident #003's care plan indicated their biggest risk of falling was transferring oneself without applying the brakes on their Personal Assistance Service Device (PASD).

During an observation, it was noted that resident #003 no longer used the PASD. An interview with RPN #122 indicated that the resident sustained an injury post fall, and they had not been using the PASD since then. During an interview, ADOC #115 acknowledged that the resident no longer used the PASD, and that the home's expectation was to revise the plan of care when their care needs changed following the fall. ADOC #115 stated that not revising the plan of care may pose a risk for staff to not provide the resident's current care needs.

Sources: Review of resident #003's care plan; Inspector #653's observation; Interviews with RPN #122, and ADOC #115. [s. 6. (10) (b)]

6. The licensee has failed to ensure that different approaches had been considered in the revision of resident #001's plan of care, when they were reassessed and the plan of care was revised because care set out in the plan had not been effective.

The home had submitted a CIR related to resident #001's unwitnessed fall that resulted in an injury.

A review of resident #001's clinical health records revealed they had a fall in April 2021, and RPN #118 indicated on the post fall assessment that they updated the resident's plan of care. During an interview, RPN #118 and Inspector #653 reviewed the changes to resident #001's plan of care, and the RPN confirmed that different approaches were not considered as no new falls interventions were added to the plan of care. During an interview, ADOC #115 acknowledged that other falls interventions could have been considered following the resident's fall. The ADOC further acknowledged that not considering different approaches in terms of falls intervention may pose a risk for another fall incident.

Sources: Review of resident #001's plan of care; Interviews with RPN #118, and ADOC #115. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
-that when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's PASD, was included in their plan of care.

During an observation, it was noted that a PASD was applied on the resident. A review of the resident's plan of care did not identify the use of PASD. An interview with the Physiotherapist (PT) indicated that they had assessed the resident after they had returned from the hospital, and approved the use of a PASD. The PT further added that it was the responsibility of ADOC #115 and the nursing team to ensure that the plan of care was updated and that it reflected their assessment. The ADOC confirmed that the plan of care for the resident did not reflect the use of a PASD. There was minimal risk to the resident, as the failure to include the use of a PASD in the plan of care, may result in unclear directions to the staff.

Sources: Review of resident #002's plan of care; Inspector #760's observation; Interviews with the PT, ADOC #115, and other staff. [s. 33. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the names of any staff members or other persons who were present at or discovered the incident, were included in the CIR that was submitted to the Director.

The home had submitted a CIR to the Director related to resident #002's fall, which resulted in an injury. A review of the CIR did not indicate the names of the staff members involved in the incident. The DOC stated they did not list down the names of the staff members in their CIRs, just their designations. The DOC further indicated they believed they were not required to put the staff names in the CIS report. Inspector #760 read the legislation to the DOC and they confirmed afterwards that they should have mentioned the staff names in the CIS report.

Sources: Review of CIR; Interview with the DOC, and other staff. [s. 107. (4) 2. ii.]

Issued on this 6th day of July, 2021

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), JACK SHI (760)
Inspection No. / No de l'inspection :	2021_823653_0015
Log No. / No de registre :	006731-21, 007037-21, 007628-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 28, 2021
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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

The licensee must ensure that the care set out in the plan of care for residents #001, #002, and #003, is provided to the residents, as it relates to their falls prevention interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care as it related to falls interventions, were provided to residents #001, #002, and #003, as specified in the plan.

A review of resident #001's care plan indicated they were at risk for falls, and staff were to implement specific falls prevention interventions.

During an observation conducted by Inspector #653 with PSW #111, and RPN #112, resident #001's falls prevention interventions were not in place.

Separate interviews with RPN #112 and Assistant Director of Care (ADOC) #115 indicated that the risk associated to not implementing the interventions was potential for another fall.

Sources: Review of resident #001's care plan; Inspector #653's observation; Interviews with PSW #111, RPN #112, and ADOC#115. (653)

2. A review of resident #002's care plan indicated they were at risk for falls, and staff were to implement a specific falls prevention intervention.

During an observation conducted by Inspector #760 with PSW #109, resident #002's falls prevention intervention was not in place. There was potential risk to the resident, as the failure to apply the intervention may result in staff not becoming immediately aware and respond when a resident may become at risk for falling.

Sources: Review of resident #002's care plan; Inspector #760'so observation; Interviews with PSW #109 and other staff. (760)

3. A review of resident #003's care plan indicated they were at risk for falls, and staff were to implement specific falls prevention interventions.

During an observation conducted by Inspector #653 with PSW #121, and RPN #119, resident #003's falls prevention interventions were not in place.

Separate interviews with RPN #119 and ADOC #115 indicated that the risk associated to not implementing the interventions was a potential fall.

Sources: Review of resident #003's care plan; Inspector #653's observation; Interviews with PSW #121, RPN #119, and ADOC #115.

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

Severity: There was minimal risk of harm to the residents, resulting from the care set out in the plan of care not provided to residents #001, #002, and #003, as specified in the plan, at the time of the inspectors' observations.

Scope: The scope of this non-compliance was widespread because the care set out in the plan of care, were not provided to three of the three residents reviewed during the inspection.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 6 (7) of the LTCHA, and 3 Written Notifications (WNs) and 3 Voluntary Plan of Corrections (VPCs) were issued to the home. (653)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 13, 2021

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 28th day of June, 2021

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