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
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée 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
Aug 05, 2022	2022_941746_0008 (A1)	017897-21, 020707-21, 005029-22	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

Amended by AMANDEEP BHELA (746) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CO #001 was rescinded.

Issued on this 5 th day of August, 2022 (A1)

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

Original report signed by the inspector.

Ontario

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 20, 2022	2022_941746_0008	017897-21, 020707-21, 005029-22	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

AMANDEEP BHELA (746)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): March 22- 25, 29 and 30, 2022.

Two logs related to medication administration and communication
One log related to abuse

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, Behavioral Supports Ontario lead (BSO Lead), Infection Prevention and Control lead (IPAC Lead, Interim Director of Care (DOC) and Executive Director (ED) and complainants.

During the course of the inspection, the inspector toured resident home areas, observed staff to resident interactions, observed medication pass, reviewed clinical health records, employee files, staff schedules, and discussed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:.
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (2) The Director of Nursing and Personal Care shall be a registered nurse. 2007, c. 8, s. 71. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Interim Director of Care is a Registered Nurse.

During an interview with the Interim Director of Care, they indicated that they are a Registered Practical Nurse.

Review of Interim Director of Care's employment file, College of Nurses of Ontario (CNO) and interview with Executive Director indicated that the Interim Director of Care who has been in this role at the home since December 2021 is a Registered Practical Nurse. The Executive Director further indicated that they have completed a Bachelor of Science in Nursing however they have not written the National Council Licensure Examination - Registered Nurses (NCLEX-RN) exam at this time.

Sources: Interview with Interim Director of Care and Executive Director and record review of employment file and CNO records. [s. 71. (2)]..

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

The Director received a complaint, that resident #001 had been abused by resident #002 on two occasions at the home.

Review of resident #002's clinical records indicated that when they were being settled into their room they heard resident #001 calling out, resident #002 then became upset. Review of resident #001's clinical records indicated that resident #002 had wandered into resident #001's room after dinner and was observed trying to get resident #001 out of bed and was heard telling them to get out of bed.

Through record review and interview's with PSW#106 and RPN #107 it was noted that, resident #002 was responsive towards resident #001. Resident #001 sustained an injury. RPN #107 indicated there was no required intervention present at the time of this incident. Further review of resident #001's clinical records and interview with PSW # 108 and RPN #107 indicated that on another identified date, resident #002 entered into resident #001's room. PSW #108 indicated that when they entered the room, resident #002 was observed pulling resident #001's leg, trying to pull the resident out of there mobility device. .

BSO Lead and Interim DOC acknowledged that these incidents were abuse. Failure to protect resident #001 from resident #002 put them at physical and emotional harm.

Sources: Clinical Records for resident #001 and #002, Interview with complainant, PSW #106 and #108 and RPN #107. [s. 19. (1)]

2. The licensee failed to ensure that resident #003 was protected from abuse by resident #002.

Review of resident #003's clinical records and interview with BSO Lead indicated that, resident #003 was heard yelling for help. Staff entered the room and observed resident #002 being responsive to resident #003. Resident #003 sustained injury and was transferred to hospital for further assessment.

BSO Lead and Interim DOC acknowledged that abuse had occurred. Failure to protect resident #003 from resident #002 put them at physical harm.

Sources: Clinical Records for resident #002 and #003, Interview with BSO Lead and Interim DOC. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002's Substitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation of resident #002's plan of care.

The Director received a complaint, indicating that the home was not informing them of incidents which were occuring with resident #002 and other residents at the home. The complainant indicated that they had become informed through a police report that resident #002 had several episodes of behavioral incidents at the home prior to an identified incident, the complainant further indicated at that time they were only informed by the home of the identified incident.

Review of resident #002's clinical records indicated that prior to that identified incident, the resident had been involved in a number of incidents, where the resident was documented found trying to remove identified residents from their rooms and or physically and verbally aggressive towards staff members.

Each of these documented notes, did not indicate that the SDM had been notified by the home..

Interview with BSO Lead and Interim DOC indicated that they cannot confirm that the home had communicated these incidents with the SDM. The home not informing the SDM of the incidents did not allow the opportunity for them to be involved in the resident #002's plan of care.

Sources: Resident #002 clinical records, Interview with complainant, BSO Lead and Interim DOC. [s. 6. (5)]

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 the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 25th day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

Order(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 sions de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDEEP BHELA (746)
Inspection No. / No de l'inspection :	2022_941746_0008
Log No. / Registre no:	017897-21, 020707-21, 005029-22
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 20, 2022
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

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:

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. 71. (2) The Director of Nursing and Personal Care shall be a registered nurse. 2007, c. 8, s. 71. (2).

Order / Ordre :

The licensee must be compliant with s. 71 (2) of the LTCHA, 2007.

Specifically the licensee must:
1. Ensure that the Director of Nursing and Personal Care is a registered nurse.

Grounds / Motifs :

1. The licensee failed to ensure that the Interim Director of Care is a Registered Nurse.

During an interview with the Interim Director of Care, they indicated that they are a Registered Practical Nurse.

Review of Interim Director of Care's employment file, College of Nurses of Ontario (CNO) and interview with Executive Director indicated that the Interim Director of Care who has been in this role at the home since December 2021 is a Registered Practical Nurse. The Executive Director further indicated that they have completed a Bachelor of Science in Nursing however they have not written the National Council Licensure Examination - Registered Nurses (NCLEX-RN) exam at this time.

Sources: Interview with Interim Director of Care and Executive Director and record review of employment file and CNO records. [s. 71. (2)]

An order was made by taking the following factors into account:
Severity: There was minimal harm or minimal risk of harm to the residents.
Scope: This issue was widespread as all the residents at the home are affected.
Compliance History: In the past 36 months, there is no compliance history for s.71 (2) (746)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2022

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee must:
1. Ensure that all residents are protected from abuse from resident #002.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

The Director received a complaint, that resident #001 had been abused by resident #002 on two occasions at the home.

Review of resident #002's clinical records indicated that when they were being settled into their room they heard resident #001 calling out, resident #002 then became upset. Review of resident #001's clinical records indicated that resident #002 had wandered into resident #001's room after dinner and was observed trying to get resident #001 out of bed and was heard telling them to get out of bed.

Through record review and interview's with PSW#106 and RPN #107 it was noted that, resident #002 was responsive towards resident #001. Resident #001 sustained an injury. RPN #107 indicated there was no required intervention present at the time of this incident. Further review of resident #001's clinical records and interview with PSW # 108 and RPN #107 indicated that on another identified date, resident #002 entered into resident #001's room. PSW #108 indicated that when they entered the room, resident #002 was observed pulling

resident #001's leg, trying to pull the resident out of there mobility device.

BSO Lead and Interim DOC acknowledged that these incidents were abuse. Failure to protect resident #001 from resident #002 put them at physical and emotional harm.

Sources: Clinical Records for resident #001 and #002, Interview with complainant, PSW #106 and #108 and RPN #107. [s. 19. (1)]
(746)

2. The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

The Director received a complaint, that resident #001 had been abused by resident #002 on two occasions at the home.

Review of resident #002's clinical records indicated that when they were being settled into their room they heard resident #001 calling out, resident #002 then became upset. Review of resident #001's clinical records indicated that resident #002 had wandered into resident #001's room after dinner and was observed trying to get resident #001 out of bed and was heard telling them to get out of bed.

Through record review and interview's with PSW#106 and RPN #107 it was noted that, resident #002 was responsive towards resident #001. Resident #001 sustained an injury. RPN #107 indicated there was no required intervention present at the time of this incident. Further review of resident #001's clinical records and interview with PSW # 108 and RPN #107 indicated that on another identified date, resident #002 entered into resident #001's room. PSW #108 indicated that when they entered the room, resident #002 was observed pulling resident #001's leg, trying to pull the resident out of there mobility device.

BSO Lead and Interim DOC acknowledged that these incidents were abuse. Failure to protect resident #001 from resident #002 put them at physical and emotional harm.

Sources: Clinical Records for resident #001 and #002, Interview with complainant, PSW #106 and #108 and RPN #107. [s. 19. (1)]
(746)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 06, 2022

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON
M7A 1N3
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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON
M7A 1N3
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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé 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
438 rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

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
438 rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416 327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of April, 2022

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amandeep Bhela

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