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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date October 7, 2022
Inspection Number 2022_1391_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long-Term Care Home and City
Langstaff Square Care Community, Richmond Hill

Lead Inspector
Britney Bartley 732787

Inspector Digital Signature
Britney Bartley Digitally signed by Britney Bartley Date: 2022.10.31 15:59:53 -04'00'

Additional Inspector(s)
Susan Semeredy 501

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 31, September 1, 2, 6, 7, 8, 2022.

The following intake(s) were inspected:

- Intake # 005567-22 Critical Incident System (CIS) report related to resident-to-resident abuse and a fall
- Intake # 006302-22 (Complaint) related to resident-to-resident abuse and a fall
- Intake # 008161-22 (Complaint) related to palliative care
- Intake # 016936-22 (Complaint) related to resident right middle upper tooth
- Intake # 012770-22 (Complaint) related to mobility device and a fall
- Intake # 008062-22 (Follow-up) related to resident-to-resident abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 19 (1)	2022_941746_000	002	Britney Bartley 732787

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (5)

The licensee has failed to ensure a resident substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of their plan of care.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint from a resident SDM with concerns of palliative measures provided to them.

A Registered Practical Nurse (RPN) received the resident's abnormal laboratory results. The nurse acted by notifying the on-call physician and assessed the resident to be asymptomatic. This assessment was provided to the physician and because the resident was asymptomatic, the physician did not order medication. The nurse confirmed they did not notify the resident's SDM of the abnormal laboratory results or the discussion they had with the physician.

A RPN was notified by the SDM of concerns with the resident's health status and their request for a treatment. The RPN informed the SDM there was no order for the treatment and that it was not needed. The RPN was unable to confirm if the on-call physician was informed of the SDM's request for the treatment. A review of the resident's clinical record indicated no documentation of such a discussion.

The Executive Director (ED) confirmed the RPN was to inform the resident's SDM of any abnormal laboratory results and another RPN was to call the on-call physician to make a clinical decision on the treatment for the resident.

By the home failing to inform the resident's SDM of abnormal laboratory results and not informing the physician of their request of the treatment, the SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Resident clinical records, interviews with RPNs #109, #110 and the ED.

[732787]

WRITTEN NOTIFICATION [PLAN OF CARE]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to as specified in the plan.

Rationale and Summary

Upon admission the home ordered routine blood work for the resident. The RPN confirmed the laboratory requisition was completed and placed in the laboratory bin for the laboratory technician to access on their next scheduled visit. The ED indicated the resident's admission blood work was not taken and there was no laboratory blood record received from the laboratory. The ED confirmed admission blood work was part of the resident's plan of care.

Failing to complete the resident's blood work put them at risk for potential health related concerns.

Sources: Resident clinical records, interviews with RPN #109 and the ED.

[732787]

WRITTEN NOTIFICATION [CARE PLANS AND PLANS OF CARE]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 24 (2) (1)*

The licensee failed to ensure that a resident's 24-hour admission care plan included any risks the resident posed to themselves, including any risk of falling, and interventions to mitigate those risks.

Rationale and Summary

The MLTC received a complaint from the resident's SDM with concerns of a mobility device and an unwitnessed fall.

The ED indicated that upon admission only transfer mobility devices are available as mobility devices for residents that needed them but did not have one of their own. The resident's admission plan of care indicated that they were at risk for falls and a mobility device was identified as an intervention.

The resident was admitted to the home after having recovered from a health condition and did not have a mobility device of their own. The resident was agitated and attempted to climb out of bed. The RPN informed the SDM of the resident's agitated state and they suggested the RPN transfer them to a mobility device. Due to the resident having weakness from a health condition, the RPN did not use one of the available transfer mobility devices because they assessed that it would pose a higher risk of a fall and injury. The RPN implemented enhanced monitoring however, the resident subsequently fell.

As a result of the admission care plan failing to include an intervention that was appropriate and mitigated the resident's risk for falls, the resident had an unwitnessed fall.

Sources: Resident clinical records, interviews with RPN #111 and the ED.

[732787]

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 2.

The licensee has failed to ensure staff members who had reasonable grounds to suspect the abuse of resident #003 by resident #004 was immediately reported to the Director.

Rationale and Summary

The MLTC received a complaint regarding a physical interaction that occurred with residents #003 and #004. The home submitted this to the MLTC as 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 CIS report and resident's clinical records indicated a physical interaction occurred between residents #003 and #004 in the hallway.

The police informed resident #003's SDM that the home reported the incident to them. The SDM stated they were not informed that the police were involved, and they never indicated anything regarding pursuing the matter as a criminal offence.

Video surveillance was reviewed, and staff interviews confirmed resident #004 was attempting to help resident #003 when resident #003 fell. The ED and Director of Care (DOC) acknowledged this was only found out later and the physical interaction should have been immediately reported as abuse and amended with their investigation findings.

Failing to report this incident as abuse resulted in family members becoming distrustful regarding the home's intentions.

Sources: CIS report, resident's clinical record, home's video surveillance, and interviews with the SDM, ED, DOC, and other staff members.

[501]

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.107(4) 3.iii

The licensee has failed to ensure that when reporting a critical incident, they are to include what other authorities were contacted.

Rationale and Summary

The home submitted CIS report to the MLTC regarding resident #003 falling, being transferred to hospital, and sustaining an injury. According to the ED, they contacted the police the day after the incident because it was a physical interaction and in retrospect should have initially reported the incident to the MLTC as abuse and included contacting the police.

There was no risk to the resident as the home had contacted the police but failed to report such to the MLTC.

Sources: CIS report, interviews with the ED and other staff members.

[501]

Review/Appeal Information

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor

Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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