Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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: (844) 231-5702
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Original Public Report

Report Issue Date: October 18, 2022
Inspection Number: 2022-1391-0001
Inspection Type: Complaint Critical Incident System
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	**Inspector Digital Signature**
Amandeep Bhela (746)	Amandeep Bhela Digitally signed by Amandeep Bhela Date: 2022.11.07 09:58:33 -05'00'

Additional Inspector(s)
Basel Mansour (741724)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 28, 29, 30, October 3 and 4, 2022.

The following intake(s) were inspected:

- Intake #00003307 (CI: 2907-000011-22) related to abuse and neglect.
- Intake #00006549 (CI: 2907-000010-22) related to responsive behaviors.
- Intake #00006388 (Complaint) related to abuse and neglect.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC ##001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (5) 3. v.

The licensee failed to ensure that a Critical Incident Report (CIR) was amended with the outcome or current status of the individual who was involved in the incident.

Rationale and Summary

The home submitted a CIR to the Director indicating that, resident #001 was transferred to hospital as a result of an incident which occurred at the home where the resident sustained significant injury.

A review of resident #001's electronic health care records indicated that the resident had been discharged from the home on an identified date.

The Executive Director acknowledged that the CIR report should have been amended with the outcome and current status of resident #001.

There was no risk posed to the resident as a result of the CIR not being amended with outcome and current status of the resident.

Sources: CIR, resident #001's progress notes and interview with Executive Director.

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