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 District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 7, 2023	
Inspection Number: 2023-1391-0002	
Inspection Type: Complaint	
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 Goldie Acai (741521)	**Inspector Digital Signature** Goldie Acai Digitally signed by Goldie Acai Date: 2023.06.09 07:48:36 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24-26, 29-31, and June 1-2, 2023

The following intake(s) were inspected:
Intake: #00002472 was related to plan of care, bathing, continence care, neglect, and responsive behaviours.
Intake: #00004589 was related to neglect.
Intake: #00005193 was related to abuse, neglect, plan of care, and menu planning; and
Intake: #00022021 was related to plan of care, reporting and complaints.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary:
A resident was observed in their room calling to staff for assistance. A staff member arrived and assisted the resident to the restroom, then left the resident to call another staff member to assist in completing the task with the resident. During this time, the resident performed a task that required supervision and assistance from staff. The staff member was to provide physical assistance to the resident, and was aware of the resident's care needs, but failed to provide the care specified in the care plan at that time.

Failure to provide the care specified in the care plan increased the residents risk of injury.

Sources: Interview with a staff member; record review of the resident care plan, risk assessment, Activities of daily living, and observations.
[741521]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee failed ensure that a resident was reassessed and the plan of care reviewed and revised when care set out in the plan has not been effective.

Rationale and Summary:
A resident was at risk for injury and required an intervention when using a mobility aide. The resident was observed on two separate dates, without this intervention being implemented by staff. A personal support worker stated that the intervention triggered behaviours, additionally, the resident had a history of refusing the intervention. A registered practical nurse and an Assistant Director of Care stated

the risk for injury increased when interventions were not reassessed when they were known to be ineffective, therefore the resident should have been reassessed at an earlier date.

Failure to reassess the resident when the intervention had not been effective increased the residents risk for injury.

Sources: Interviews with a PSW, an RPN, and an Assistant Director of Care; record review of the resident's care plan, and assessments; and observations.
[741521]

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