Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2017	2016_251512_0019	033433-16	Resident Quality Inspection

Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street TORONTO ON M5T 1J7

Long-Term Care Home/Foyer de soins de longue durée

MON SHEONG HOME FOR THE AGED
36 D'ARCY STREET TORONTO ON M5T 1J7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TILDA HUI (512), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 5, 7, 8, 9, 12, 13, 14, and 15, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DORC), Food Services Supervisor (FSS), Programs & Social Services Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide (DA), Residents, Family Members and Substitute Decision Makers (SDMs).

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 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	Legendé 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #007 was triggered for inspection by the identification of a new/worse pressure ulcer during census review at stage I of the RQI.

Review of the resident's current written plan of care with an identified date, revealed focus, goal and interventions were set up to address the resident's potential pressure ulcer. Review of the wound assessment dated four months prior to the current care plan revision date, revealed the resident experiencing an altered skin integrity. Treatment was to apply topical medication to the wound daily until healed. Review of the wound assessment dated two months prior to the care plan revision date, revealed the treatment of the wound has changed to another topical medication daily until healed. Wound assessment dated around the same time frame as the current care plan revision date, revealed the altered skin integrity had healed with wound site intact. Treatment was discontinued after the assessment.

Review of the list of weekly wound assessments revealed assessments were not conducted weekly for two identified dates when the resident's altered skin integrity remained open.

Observation of the resident conducted during the inspection period revealed the resident's skin was intact. The resident was not able to be interviewed.

During interviews, PSW #117 and PSW#114 indicated the resident had multiple skin integrity issues. The RPN stated the resident's skin was intact at the moment and all altered skin integrity had healed. RPN #114 stated staff had been conducting weekly wound assessment for the resident and could not understand why there were no evidence of any weekly wound assessment conducted for the resident during the above mentioned two dates.

Interview with the DORC, lead for the skin and wound program stated that registered staff were expected to conduct weekly wound assessments for residents experiencing open wounds, and confirmed that weekly wound assessment were not conducted for resident #007 for the above mentioned two dates. [s. 50. (2) (b) (iv)]

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 that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

This inspection was initiated as a mandatory task within the Resident Quality Inspection (RQI) commenced on December 5, 2016.

Observation was made during the inspection period on an identified unit in the medication room of the medication cart. A box with 11 keys were noted on the top drawer of the medication cart.

Interview with RPN #118 indicated the keys should not be kept on the medication cart and removed the keys promptly. Interview with the DORC confirmed that the medication cart should be used exclusively for drugs and drug related supplies. [s. 129. (1) (a)]

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 that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

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. (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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that nursing staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #005 was triggered for inspection during stage one of this Resident Quality Inspection (RQI). Observation revealed the use of potential restraint on the resident.

Review of the resident's current written plan of care with an identified date revealed the use of a wheelchair with an identified device as PASD whenever the resident was up. The plan of care indicated the device was used for positioning when the resident was in the wheelchair, and that the resident was not able to rise from the chair.

During an interview, PSW #108 indicated that he/she was aware that the resident uses the wheelchair when up. However, the PSW was not aware that a device was being used when the resident was up in the chair. The PSW indicated that he/she had never seen the device being used. Interview with RN #107 stated that the resident did use the device whenever the resident was up. However, the resident's family requested that the device be used only when the family members were present, and that the device was stored at all times.

Interview with the DORC confirmed there was a lack of collaboration between nursing staff in the assessment and implementation of the plan of care for the resident resulting in misunderstanding in some of the PSWs as to the use of the identified device. [s. 6. (4) (a)]

2. The licensee has failed to ensure that resident #004 was reassessed when the resident's bowel continent care needs changed.

Resident #004 was triggered for inspection by the most recent Minimum Data Set (MDS) assessment to be at a low risk for bowel incontinence during stage I of the Resident Quality Inspection (RQI).

Record review of resident's MDS assessment with an identified date, revealed the resident's bowel continence status as continent. Review of the resident's written plan of care and MDS assessment dated three months later, revealed the resident's bowel continence status as usually continent. There were focus, goals, and intervention set up to address the resident's bowel incontinence. However, record review did not reveal a bowel continence assessment conducted on the resident on or after the most recent MDS assessment date when the resident was identified to be deteriorated one level in his/her continence level.

During interviews, PSW #101, and RN #102 indicated the resident had occasional bowel incontinence recently. RN #102 admitted that a bowel continence assessment was not conducted on the resident since the deterioration. An interview with the DORC who was the lead for the continence program confirmed that a bowel continence assessment should have been conducted on the resident upon identification of the bowel continence deterioration. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are provided with a range of continence care products based on their individual assessed needs.

This inspection was triggered for resident #002 at stage I from the most recent MDS related to incontinence. Review of resident #002's current written plan of care, under bladder and bowel incontinence focus both revealed that resident wears an identified type of incontinent products during the day, and a second type of products at night. Review of the Nursing Daily Record for an identified month for resident #002 revealed that resident wears the second type of products only. Review of the unit's 'Incontinent Products Size Record' form revealed that the first identified incontinent product during the day and the second type of products during the night were ordered for resident #002 until four months prior to the identified month. Since three months prior to the identified month, only the second type of incontinent products were ordered for the resident.

Interviews with resident #002, PSW #108, RPN #104, and RN #102 revealed that the resident currently only used the second type of products and was no longer provided with the first type. RPN # 104 and RN #102 further revealed that the care plan stated the first type of products during the day and the second type at night, but that the resident was only provided with the second type of incontinent products for day and night.

PSW #108 and RN #102 further revealed that because resident often requests for changes of his/her incontinent product even when the product was not wet or only a little wet, it was more economical to provide resident with the second type of products which cost less.

Interview with the DORC revealed that it is the home's expectation for staff to review and follow the care plan, and confirmed that the home did not provide resident with his/her continence care based on his/her assessed needs on the care plan. [s. 51. (2) (h) (i)]

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Issued on this 30th day of January, 2017

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

Original report signed by the inspector.