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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 26, 2015	2014_219211_0027	T-000075-14	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 RICHMOND HILL LONG TERM CARE CENTRE
11199 YONGE STREET RICHMOND HILL ON L4S 1L2

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

JOELLE TAILLEFER (211), JANET GROUX (606), NATASHA JONES (591)

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 22, 23, 24, 29, 30, 31, 2014 and January 5, 6, 7, 8, 2015

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DORC), assistant director of resident care (ADORC), manager of building service, support service supervisor, registered dietician (RD), activation supervisor, manager of nutrition and dietary service, resident assessment instrument coordinator (RAI), education coordinator, manager of social services, physiotherapist (PT), registered nursing staff, personal support workers (PSWs), housekeeping, Family Council members, Resident's Council members, residents, substitute decision makers (SDM) and volunteers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
4 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy put in place is complied with.

Review of the home’s policy titled “Pain Management Program” # RC-4.8, revised June 2013, revealed that the registered staff shall conduct and document a pain assessment quarterly for residents who are on pain management regardless of whether the pain is relieved or unrelieved.

Record review indicated and interview with identified registered staff revealed that resident #15 is experiencing pain to two specific areas of the body.

Review of the quarterly pain assessment and interview with the assistant director of resident care (ADORC) indicated that a quarterly assessment was completed on two identified days. The ADORC confirmed that a quarterly pain assessment should have been completed on an identified day and the pain management program policy was not complied with. [s. 8. (1) (b)]

2. Review of the home's policy titled "Pain Management Program" #RC-4.8 revised June 2013, revealed that the registered staff must conduct and document a pain assessment when pain is identified upon admission, quarterly for resident who is on pain management no matter if the pain is relieved or unrelieved, and new onset of pain.

Record review revealed that for resident #24, pain assessments were completed on two identified days.

Interviews with resident #24 on two identified days revealed that he/she has pain to two specific areas of the body.

Interview with an identified registered staff revealed that the resident has pain to two areas of his/her body and a pain assessment was not completed quarterly.

Interview with the educator confirmed that a quarterly pain assessment should have been completed for this resident. [s. 8. (1) (b)]

3. Record review of the Vaccine Temperature Log Book revealed that on an identified day, the vaccine fridge temperature was not recorded on the evening shift.
Record review of the policy #IC-2.6.5 titled Vaccine Storage and Transportation, revised November 2014, revealed that the RN/RPN shall monitor and document refrigerator temperature twice daily on Vaccine temperature log book, including the time and the temperature taken.

Interviews with an identified registered staff and the DORC revealed that the vaccine fridge should be checked twice daily and confirmed that the policy was not complied with. [s. 8. (1) (b)]

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 policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home immediately forward any written complaints that have been received concerning the care of a resident to the Director.

Record review of the critical incident report binder revealed that several written complaints dated on six specific days, were received by the home from resident family members concerning the care of residents and were not immediately submitted to the Director.

Interviews with the Administrator and the DORC revealed that the above mentioned written complaints should have been immediately submitted to the Director. [s. 22. (1)]

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 home immediately forward any written complaints that have been received concerning the care of a resident to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Record review of the concern and complaint binder revealed that verbal complaints, responses provided to the complainants and responses from the complainants were not recorded.

Interviews with the Administrator and the DORC confirmed that verbal complaints, responses provided to the complainants and responses from the complainants were not recorded. [s. 101. (2)]

2. The licensee has failed to ensure that the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly and a written record is kept of each review and of the improvements made in response.

Record review of the document titled "Complaints Analysis Report 2014" revealed that the analysis was completed once in a specific year, and the written record did not include the improvements made.

Interviews with the administrator and the DORC confirmed that the documented record of complaints received was reviewed and analyzed annually but should have been reviewed quarterly and that the written document did not include the improvements made. [s. 101. (3)]

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:
-a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

-the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly and a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Observations made on a specific day, of the care supply cabinet in three different units of the spa/shampoo room revealed dirty kidney basins with several rusty toenail clippers, nail clippers, unlabelled dirty combs and a brush with hair.

Interview with identified registered staff and personal support workers on a specific day, confirmed that the nail clippers were rusted and should not be used for residents care and combs and the brush should be labelled. [s. 229. (4)]

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 that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observations made on two specific days, revealed that the right toilet grab bar attached to the wall was found to be loose in resident #31’s bathroom. Interview with an identified PSW on a specific day, confirmed that the right toilet grab bar was loose and needed to be repaired.

Interview with the support services supervisor (SSS) on a specific day, confirmed that he/she was informed by the maintenance staff that the right toilet grab bar was loose and needed to be repaired.

Observation made on the same day, confirmed that the grab bar was repaired. [s. 5.]

WN #6: 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 the staff and others involved in the different

aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Review of the nursing and personal support services flow sheets indicated that resident #41 had frequent incidences of incontinence for thirty-three specific days. Record review indicated that a continent assessment was not completed during that time.

Interview with an identified registered staff revealed that a continence assessment should have been completed when the resident's continence status changed from continent to incontinent.

Interview with the ADORC confirmed the registered staff should have completed an assessment titled "change in continence status" in the point click care (PCC) record when the resident became incontinent of bowel during that time. [s. 6. (4) (a)]

2. The licensee has failed to 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 the resident's care needs change.

Interview with the physiotherapist revealed that resident #22 was suffering from pain and was controlled with treatment.

Review of the medication administration record (MAR) indicated that resident #22 received an analgesic for eleven days in a month for pain.

Review of two quarterly written plans of care, revealed that the written plan of care was not updated addressing specifically the interventions for pain.

Interview with the education coordinator and the ADORC confirmed that the written plan of care was not updated when the resident's care needs changed. [s. 6. (10) (b)]

3. Review of the current quarterly written plan of care, indicated that resident #41 was incontinent. Record review revealed in the Minimum Data Set (MDS) assessment on the same quarterly period, that the resident was continent.

Interview with the ADORC confirmed that the current quarterly written plan of care was not updated and did not reflect the MDS assessment dated on the same quarterly period.

[s. 6. (10) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on an interdisciplinary assessment with respect to the resident's pain.

Interviews with resident #24 revealed that the resident has pain to two specific areas of his/her body.
Interview with an identified registered staff revealed that the resident has pain in those areas but this was not documented in the plan of care.

Record review of the most recent plan of care for resident #24 revealed that the two specific areas of a pain were not included in the plan of care.

Interview with the educator confirmed that the resident's pain should have been documented in the plan of care. [s. 26. (3) 10.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Record review revealed that resident #19 was identified at nutritional risk related to his/her low body mass index (BMI) based on a completed admission nutritional assessment.

Record review of the resident #19's plan of care revealed that there was no documentation of the intervention of the dietary supplements recommended by the registered dietician (RD) for the resident's low weight and body mass index (BMI) score.

Interview with the registered dietician confirmed the discussion with the resident was not documented. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident’s pain is not relieved by initial interventions; the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Review of the medication administration record (MAR) indicated that resident #22 received an analgesic for eleven days in one month for the pain.

Review of the home’s policy titled “Pain Management Program” # RC-4.8, revised June 2013, indicated that the registered staff shall conduct and document a pain assessment when the resident is experiencing a new onset of pain.

Interviews with an identified registered staff and the ADORC revealed that when the resident has new onset of pain, the registered staff shall complete an assessment titled “new onset of pain” in the point click care (PCC) record.

Interview with the educator coordinator confirmed the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responds in writing within 10 days of receiving advice from the Family Council.

Record review of the Family Council complaint letter dated on a specific day, revealed that the home did not respond in writing within ten days.

Record review of the home's policy titled "Complaint Procedure" # RC-2.3 dated July 2010, indicated that the administrator or designate will inform the complainant the result of the investigation within ten business days.

Interview with the administrator confirmed that the home did not respond to the Family Council within ten days. [s. 60. (2)]

Issued on this 27th day of January, 2015

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

Original report signed by the inspector.