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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_650565_0014	023988-17	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

MATTHEW CHIU (565), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 18, 19, 20, 23, 24, 25, and 26, 2017.

During the course of the inspection, the following Critical Incident System Intake was inspected:
- 023739-16 related to medication incidents and adverse drug reactions.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Resident Care (ADRC), Social Service Manager (SSM), Registered Dietitian (RD), Physiotherapists (PTs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During stage one of the Resident Quality Inspection (RQI), resident observation revealed potential restraints for resident #005.

On an identified date, the inspector observed resident #005 wearing the identified medical devices when he/she was sitting in a wheelchair. Further observation on another identified date indicated the resident was not wearing the identified medical devices.

Review of resident #005's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment and the current plan of care indicated the resident had both cognitive and physical impairments. The resident required specified assistance for care and transfer.

Further review of resident #005's plan of care, under the focus of use of Personal Assistance Services Device (PASD), revealed the resident should continue to wear the identified medical devices for a specified condition. The plan of care did not specify when to apply the identified medical devices for the resident.

Interview with Personal Support Worker (PSW) #110 indicated he/she was unsure if the resident required wearing the identified medical devices.

Interview with PSW #112 indicated the resident had an identified change in his/her health status. Staff would apply the identified medical devices only when staff observed the resident's had the specified condition.

Interview with Registered Practical Nurse (RPN) #111 indicated the plan of care for resident #005 did not set out clear direction about when to apply the identified medical devices for the resident, and therefore he/she would interpret it as the resident should wear the devices all the time.

Interview with the Acting Director of Resident Care (ADRC) indicated that the written plan of care for resident #005 should have included direction to staff on when to apply the resident's identified medical devices. The ADRC acknowledged that the plan of care for resident #005 did not set out a clear direction related to the application of the identified medical devices as required. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living included in a resident's plan of care only if alternatives to the use of the PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

Resident #001 triggered from stage one of the RQI for minimizing of restraining related to potential restraints.

Observations on an identified date revealed resident #001 was using an identified physical device while up in the wheelchair. Another observation on another identified

revealed the resident's wheelchair was set at a specified position and the identified physical device was applied to the resident.

Record review indicated the resident was admitted to the home on an identified date. Further review of the RAI-MDS assessment indicated the resident is cognitively intact but he/she was not interterviewable during stage one of the RQI.

Review of resident #001's written plan of care indicated the resident uses a specified wheelchair position and the identified physical device for the specified purposes. These were being documented as a PASD according to the identified records.

Record review of resident #001's identified assessment record indicated the use of the specified wheelchair position and the identified physical device for the specified purposes. Review of another identified assessment record indicated the continued use of the wheelchair position and the physical device for the same purposes.

Interviews with RN #104 and Physiotherapist (PT) #109 revealed the resident's specified physical function. The use of the specified wheelchair position and the identified physical device was to achieve the same specified purposes when the resident was up in the chair. RN #104 confirmed that no alternatives had been tried prior to initiating the use of the identified physical device.

Interview with PT #109 revealed that the identified physical device and the specified wheelchair position were recommended for the specified purposes. The PT confirmed that in his/her experience the trial of other alternatives would require a longer assessment period than the identified period, and there was no other trial thereafter.

Interview with the ADRC revealed that resident #001's specified physical function had changed since admission, and the home missed a step to trial other alternatives prior to initiating the use of the identified physical device. [s. 33. (4) 1.]

2. During stage one of the RQI, resident observation revealed potential restraints for resident #005.

Further observation on an identified dated indicated resident #005 was in a specified wheelchair position and an identified physical device was being applied at the same time.

Review of resident #005's RAI-MDS assessment and the plan of care indicated the resident had specified impairments and required specified assistance for care and transfer.

Further review of resident #005's plan of care indicated the resident had been using the specified wheelchair position and identified physical device for an identified period of time. They were being documented as PASD.

Review of resident #005's identified assessment records revealed on an identified date, both the specified wheelchair position and identified physical device were first documented to use for the specified purposes. Further review of all the assessments revealed no evidence of alternatives to the use of the specified wheelchair position and identified physical device had been considered and tried in relation to the above mentioned purposes.

Interviews with PSW #110 and RPN #111 indicated resident #005 required specified care and assistance for transfer. The use of the specified wheelchair position and identified physical device was to achieve the specified purposes while the resident was in wheelchair. The staff members stated the resident was incapable to remove the identified physical device on his/her own. RPN #111 further stated resident #005's specified functional capability in relation to the specified wheelchair position, and the RPN was not aware if alternatives to the PASD had been tried.

Interview with PT #115 who had involved in recommending the PASD for resident #005 indicated the resident had specified physical functions. The specified wheelchair position and identified physical device were recommended for the specified purposes. PT #115 further indicated the identified physical device would limit some of the resident's freedom of movement when he/she was in the wheelchair. PT #115 confirmed that no alternatives, such as using the specified wheelchair position alone, had been tried for achieving the specified purposes for the resident prior to the use of the identified physical device.

Interview with the ADRC indicated that one of the expectations prior to using the PASD, which has the effect of limiting or inhibiting a resident's freedom of movement, is to consider and try alternatives. The ADRC stated prior to using the identified physical device for resident #005, staff should consider and try using the specified wheelchair position for achieving the specified purposes, and evaluate the effectiveness. The ADRC confirmed that alternatives to the use of the PASD for resident #005 had not been

considered and tried as required. [s. 33. (4) 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 use of a PASD under subsection (3) to assist a resident with a routine activity of living included in a resident's plan of care only if alternatives to the use of the PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of Residents’ Council meeting minutes dated September 15, 2017, revealed that during the meeting, the Residents' Council had raised concerns related to the follow areas:
- Too much bleach is added to the laundry.
- Residents’ personal cups to be washed by staff as some residents are unable to was their own.
- Residents are difficult to wheel back from the Mae Garden into the building as the entrance is not smooth.

Review of the home’s Concerns and Complaints Form dated September 15, 2017, indicated that the above mentioned concerns had been recorded on the form with corresponding written responses from different responsible staff members. The dates of the responses are September 26 and 27, 2017. The form was signed off by the Administrator on September 27, 2017, and the Residents’ Council Chair on September 28, 2017.

Interview with the Residents’ Council Chair indicated the above mentioned concerns were discussed during the meeting, and the written responses were shared with him/her by the Social Service Manager (SSM) on September 28, 2017.

Interviews with the SSM and the Administrator indicated that the home responds to the Residents’ Council's concerns and recommendations in writing by using the Concerns and Complaints Form. The SSM is responsible to complete the form by gathering responses from responsible department managers. The form will be given to the Residents’ Council Chair after it was signed off by the Administrator. The SSM and the Administrator confirmed that the home received the above mentioned concerns on September 15, 2017, and responded to the Residents’ Council in writing on September 28, 2017, but not within 10 days. [s. 57. (2)]

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 licensee shall respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

Observation of a medication administration on an identified date and time on an identified home area revealed RPN #100 left the medication cart unlocked when he/she stepped away from the medication cart to administer the medications to resident #008 in his/her room.

Interview with RPN #100 revealed that the medication cart should have been locked when he/she stepped away from the medication cart to administer medications to resident #008.

Further to the observation, an identified incident happened in resident #008's room during observation of the medication administration and the RPN returned to the medication cart and placed resident #008's identified medications on top of the opened MAR on the medication cart located outside of the resident room. The RPN re-entered the resident's room to perform identified actions and then returned to the medication cart.

Interview with RPN #100 revealed that he/she knew that the resident's identified medications should not have been left on the top of the medication cart.

Interview with ADRC revealed that the security of the medication is important and absolutely no doubt the medication cart should be locked when the nurse went into the resident room to administer the medication. [s. 130. 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 steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Review of Critical Incident System (CIS) report indicated that resident #007 had been administered resident #009's medications on an identified date and time.

Interview with RPN #100 revealed that on the identified date, he/she had mistakenly administered resident #009's medications to resident #007. According to the RPN, he/she did not check the strip packaging against the MAR before he/she had administered resident #009's medications to resident #007. The RPN further revealed that he/she became aware of the error when he/she attempted to administer medications to resident #009 and the medications were not available and resident #007 complained of specified health condition. Subsequent identified actions were taken, and the RPN further confirmed that it was his/her fault that he/she had given resident #009's medications to resident #007.

Further review of the CIS report under long-term care actions to correct this situation and prevent recurrence indicated a medication administration will be conducted with this registered staff.

A review of the home's record of a medication pass audit completed by the pharmacy service provider on an identified date of RPN #100 indicated medications were not prepared immediately prior to administration and the medication cart was unlocked when left unattended.

Interview with RN #107 revealed that the RPN had reported to him/her that he/she had accidentally given resident #009's medications to resident #007. According to the RN, he/she did not investigate further as this is usually done by the DRC.

The DRC was not available for interview as he/she had retired.

Interview with the ADRC confirmed that RPN #100 had administered the incorrect medications to resident #007 on the identified date that had not been prescribed to the resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the family satisfaction survey.

Review of the Family Council meeting minutes in 2017 revealed no records about the home seeking advice of the Council in developing and carrying out the 2017 family satisfaction survey.

Interview with two identified Family Council members indicated the home had conducted a family satisfaction survey in August and September 2017. The Family Council members stated they were not aware of the home's 2017 family satisfaction survey until they received the home's email invitation to complete the survey as being the family of the residents. The Family Council members further indicated that the home had started using SurveyMonkey as one of the means to complete the survey for this year, and the home did not seek the advice of the Family Council in developing and carrying out the survey prior to this.

Interview with the Administrator indicated that the home has started using SurveyMonkey for families to complete the survey this year, and continued to use the same survey questions as in last year. The Administrator confirmed the home did not seek the advice of the Family Council in developing and carrying out the 2017 family satisfaction survey. [s. 85. (3)]

Issued on this 14th day of December, 2017

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

Original report signed by the inspector.