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
May 22, 2018	2018_486653_0007	017897-16, 005567-18	Critical Incident System

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 6, 9, 10, 11, and 12, 2018.

The following intakes were inspected concurrently during this inspection:
Critical Incident Log #s:
017897-16 related to abuse,
005567-18 related to falls.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed staff schedule, clinical health records, staff training records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the Director of Resident Care (DORC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the residents were free from abuse by the licensee or staff in the home.

On an identified date and time, the home submitted a Critical Incident System (CIS) report to the Director, related to alleged abuse. The CIS report indicated that on an identified date and time, Personal Support Worker (PSW) #108 had performed inappropriate actions towards resident #002.

A review of resident #002's written plan of care on an identified date, indicated the resident had identified responsive behaviours and was at risk of falls.

An interview with PSW #108 stated that on an identified date and time, resident #002 started to be restless and was getting out of the bed. The PSW helped the resident go to the washroom but the resident was still restless and kept getting out of the bed. PSW #108 transferred resident #002 to their assistive device and transported the resident to the TV lounge. The PSW further indicated that they sat beside the resident, provided the resident with an activity, which the resident threw away. Afterwards, PSW #108 provided resident #002 with another activity to do. The PSW turned off the lights to promote sleep but the resident did not sleep, and made a lot of noise with their assistive device by hitting it against the wall.

An interview with Registered Practical Nurse (RPN) #109, revealed that on an identified date and time, while they were taking their break, they heard a noise that sounded like "a person banging on a hard surface". RPN #109 walked over to check and had seen resident #002 sitting in their assistive device in the lounge with no lights on. RPN #109 asked PSW #108, who was sitting at the nursing station, why the resident was placed in the TV lounge. The PSW stated to RPN #109 that resident #002 had gotten up from their bed an identified number of times and this was a way to prevent the resident from falling. PSW #108 was noted to remove an identified object from the resident's assistive device used to hold the resident in place.

RPN #109 asked the PSW to take the resident back to their room, but the PSW disagreed and they started to argue with each other. PSW #108 stated to the RPN that if the resident was brought back to their room, the PSW will not be responsible if the resident fell or got hurt. After arguing, RPN #109 agreed with PSW #108 to keep resident #002 in the TV lounge. PSW #108 brought back the identified object, placed it around resident #002's identified area of the body to hold the resident in place, as witnessed by RPN #109. Resident #002 was left in the same condition for an hour, and at an identified time, the resident was taken back to bed by PSW #108 and RPN #109. The RPN indicated that the resident's skin was assessed and intact. RPN #109 further indicated

that at the time of the incident, they were aware that restraining the resident to the assistive device in the TV lounge was wrong and they did not make the right judgment by leaving the resident in this position for over an hour. After reflecting on the incident, RPN #109 reported the incident to the Director of Resident Care (DORC) on an identified date, as the RPN recognized the incident as abuse.

An interview with the DORC indicated that following the home's immediate internal investigation, PSW #108 was terminated and a letter issued to the PSW on an identified date stated that the home had found them not to be truthful during the investigation, and had been inappropriate toward resident #002 during the identified shift. The DORC further indicated that PSW #108 should have considered alternatives such as satisfying the resident's needs to get them settled, or call the nurse or the other PSW to provide resident #002 with the care or assistance they required in this situation, instead of restraining resident #002. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

On an identified date and time, the home submitted a CIS report to the Director, related to alleged abuse. The CIS report indicated that on an identified date and time, PSW #108 had performed inappropriate actions towards resident #002.

An interview with RPN #109, revealed that on an identified date and time, while they were taking their break, they heard a noise that sounded like "a person banging on a hard surface". RPN #109 walked over to check and had seen resident #002 sitting in their assistive device in the TV lounge, with no lights on. Resident #002 was observed using the palm of their hand patting repetitively on one level of the bookshelf. RPN #109 asked PSW #108, who was sitting at the nursing station, why the resident was placed in the TV lounge. The PSW stated to RPN #109 that resident #002 had gotten up from their bed an identified number of times and this was a way to prevent the resident from falling. PSW #108 was noted to remove an identified object from the resident's assistive device.

RPN #109 asked the PSW to take the resident back to their room, but the PSW

disagreed and they started to argue with each other. PSW #108 stated to the RPN that if the resident was brought back to their room, the PSW will not be responsible if the resident fell or got hurt. After arguing, RPN #109 agreed with PSW #108 to keep resident #002 in the TV lounge. PSW #108 brought back the identified object and placed it around resident #002's identified area of the body, and tied it to the back of the assistive device, as witnessed by RPN #109. Resident #002 was left in the same condition for an hour, and at an identified time, the resident was taken back to bed by PSW #108 and RPN #109. The RPN indicated that the resident's skin was assessed and intact. RPN #109 further indicated that at the time of the incident, they were aware that restraining the resident in the assistive device was wrong and they did not make the right judgment by leaving the resident in this position for over an hour. After reflecting on the incident, RPN #109 reported the incident to the DORC on an identified date, as the RPN recognized the incident as abuse.

A review of the home's investigation notes indicated that on an identified date, the Assistant Director of Resident Care (ADORC) and DORC received a report from RPN #109 that PSW #108 had performed inappropriate actions towards resident #002 during the identified shift.

An interview with the DORC confirmed the above mentioned information and further indicated that the previous DORC had conducted the internal investigation first, prior to reporting the allegation of abuse to the Director. The DORC acknowledged that the home had failed to report the allegation of abuse immediately as required. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that no resident of the home was restrained by the use of physical device, other than in accordance with section 31 or under the common law duty described in section 36.

The LTCHA, 2007, s. 31 "A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care". S. 36 "Nothing in this Act affects the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others".

On an identified date and time, the home submitted a CIS report to the Director, related to alleged abuse. The CIS report indicated that on an identified date and time, PSW #108 had performed inappropriate actions towards resident #002.

A review of resident #002's written plan of care on an identified date revealed they were at high risk for falls and had indicated interventions to prevent the resident from falling. Further review of resident #002's written plan of care did not identify information in regards to restraints.

Resident #002 had been discharged from the home on an identified date, and could no longer be interviewed.

An interview with RPN #109, revealed that on an identified date and time, while they were taking their break, they heard a noise that sounded like "a person banging on a hard surface". RPN #109 walked over to check and had seen resident #002 sitting in their assistive device in the TV lounge, with no lights on. Resident #002 was observed using the palm of their hand patting repetitively on one level of the bookshelf. RPN #109 asked PSW #108, who was sitting at the nursing station, why the resident was placed in the TV lounge. The PSW stated to RPN #109 that resident #002 had gotten up from their bed an identified number of times and this was a way to prevent the resident from falling. PSW #108 was noted to remove an identified object from the resident's assistive device.

RPN #109 asked the PSW to take the resident back to their room, but the PSW disagreed and they started to argue with each other. PSW #108 stated to the RPN that if the resident was brought back to their room, the PSW will not be responsible if the resident fell or got hurt. After arguing, RPN #109 agreed with PSW #108 to keep resident #002 in the TV lounge. PSW #108 brought back the identified object and placed it around resident #002's identified area of the body, and tied it to the back of the assistive device, as witnessed by RPN #109. Resident #002 was left in the same condition for an hour, and at an identified time, the resident was taken back to bed by PSW #108 and RPN #109. The RPN indicated that the resident's skin was assessed and intact. RPN #109 further indicated that PSW #108 restrained resident #002 by applying an identified object on the resident's identified area of the body to keep the resident from standing up from their assistive device.

An interview with the DORC confirmed the above mentioned information and acknowledged that the identified object was prohibited to be used to restrain a resident. The DORC further indicated that PSW #108 should have considered alternatives such as satisfying the resident's needs to get them settled, or call the nurse or the other PSW to help the resident in this situation, instead of restraining resident #002. [s. 30. (1) 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 no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

On an identified date and time, the home submitted a CIS report to the Director, related to alleged abuse. The CIS report indicated that on an identified date and time, PSW #108 had performed inappropriate actions towards resident #002.

A review of the home's abuse policy #RC – 2.2, indicated that all staff and volunteers immediately report any and all alleged, suspected, or witnessed incidents of resident abuse and neglect, improper or incompetent treatment/ care or neglect to the Director of Resident Care. If the incident occurs after office hours, such incidents are reported to the in-charge Registered Nurse.

An interview with RPN #109, revealed that on an identified date and time, while they were taking their break, they heard a noise that sounded like "a person banging on a hard surface". RPN #109 walked over to check and had seen resident #002 sitting in their assistive device in the TV lounge, with no lights on. Resident #002 was observed

using the palm of their hand patting repetitively on one level of the bookshelf. RPN #109 asked PSW #108, who was sitting at the nursing station, why the resident was placed in the TV lounge. The PSW stated to RPN #109 that resident #002 had gotten up from their bed an identified number of times and this was a way to prevent the resident from falling. PSW #108 was noted to remove an identified object from the resident's assistive device.

RPN #109 asked the PSW to take the resident back to their room, but the PSW disagreed and they started to argue with each other. PSW #108 stated to the RPN that if the resident was brought back to their room, the PSW will not be responsible if the resident fell or got hurt. After arguing, RPN #109 agreed with PSW #108 to keep resident #002 in the TV lounge. PSW #108 brought back the identified object and placed it around resident #002's identified area of the body, and tied it to the back of the assistive device, as witnessed by RPN #109. Resident #002 was left in the same condition for an hour, and at an identified time, the resident was taken back to bed by PSW #108 and RPN #109. The RPN indicated that the resident's skin was assessed and intact. RPN #109 further indicated that at the time of the incident, they were aware that restraining the resident in the assistive device was wrong and they did not make the right judgment by leaving the resident in this position for over an hour. The RPN confirmed to the inspector that they did not report the incident to the charge nurse at the time of the incident, reported it late to the DORC, and acknowledged that they did not follow the home's policy on abuse.

A review of Registered Nurse (RN) #110's signed written statement revealed that they did not receive any report from any staff regarding an issue on the identified shift. The RN indicated they were the in-charge nurse on that shift.

A review of the home's investigation notes indicated that on an identified date, the ADORC and DORC received a report from RPN #109 that PSW #108 had performed inappropriate actions towards resident #002 during the identified shift.

An interview with the DORC acknowledged the above mentioned information and confirmed that RPN #109 did not comply with the home's policy on abuse as the RPN delayed the reporting of the potential abuse incident. [s. 20. (1)]

Issued on this 12th day of June, 2018

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

Original report signed by the inspector.