Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2020	2020_823653_0009	003057-20	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): March 5, 6, 9, 10, 11, 12, 2020.

During the course of the inspection, Complaint Log #003057-20 related to allegation of abuse, responsive behaviours, and complaint procedures in the home, was inspected.

During the course of the inspection, the inspector conducted observations of resident interactions, provision of care, reviewed the staff schedule, clinical health records, staff training records, the home's complaints binder, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Maker, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) Registered Nurses (RNs), Behavioural Support Resource (BSR) Team Lead, Social Worker (SW), Director of Resident Care (DORC), the Assistant Administrator (AA), and the Administrator.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **7 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	Légende 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 has failed to ensure that resident #001 was protected from abuse by

resident #002.

The Ministry of Long-Term Care (MLTC) received a complaint which indicated that resident #002 entered resident #001's room without their permission and displayed inappropriate action towards resident #001. The incident had been brought to the attention of the Director of Resident Care (DORC) but the resolution was not satisfactory.

An interview with the complainant indicated on an identified date, resident #001 informed their visiting Substitute Decision-Maker (SDM) that co-resident #002 went into their bedroom several times without permission, and resident #002 displayed inappropriate action towards resident #001.

A review of resident #001’s Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment indicated they had cognitive impairment.

An interview with resident #001 with the assistance of an interpreter, indicated there was one time wherein co-resident #002 entered their bedroom and displayed inappropriate action towards resident #001. Resident #001 stated they went to the door and asked for help, and one of the staff members came and resident #002 returned to their own room. Resident #001 stated they felt very upset about the incident, and that co-resident #002 entered their room three times without their permission, and it all happened in a span of one week.

A review of resident #002’s RAI-MDS assessment indicated they had cognitive impairment.

During an interview with resident #002 with the assistance of an interpreter, resident #002 became visibly upset and agitated, so the interview had to be concluded immediately.

An interview with Personal Support Worker (PSW) #100 indicated there was one incident wherein resident #001 was outside of their bedroom, in the hallway, and had called for help. Resident #001 reported to the PSW that resident #002 displayed inappropriate action towards resident #001. PSW #100 redirected resident #002 back to their bedroom and the PSW reported the incident to their Registered Practical Nurse (RPN) and were told to keep an eye on both residents. PSW #100 could not recall the exact date of the incident nor could recall who the RPN on duty was at that time.

An interview with Registered Nurse (RN) #113 indicated they were made aware during change of shift of report of the reported incident by resident #001 that resident #002 allegedly entered their room and displayed inappropriate action towards resident #001. The RN could not recall if the change of shift report they received was on the day of the incident, and could not recall the registered staff they received the report from. RN #113 further indicated they were told that during their colleague’s duty, they heard resident #001 called for help and the staff found resident #002 in resident #001's room, and immediately redirected resident #002 out of the room.

An interview with the Behavioual Support Resource (BSR) Team Lead indicated they recalled a floor nurse reported to them that resident #001 said co-resident #002 went to their room and displayed inappropriate action towards resident #001. The BSR Team Lead indicated that was the time they implemented two interventions to prevent co-residents from entering resident #001's bedroom. The BSR Team Lead also instructed resident #001 to use the call bell if they felt they were in danger. The BSR Team Lead stated they did not interview resident #001 about the reported incident, but let the resident know about the interventions they had implemented. The BSR Team Lead could not recall the floor nurse who reported the alleged incident to them.

A review of resident #001 and #002’s progress notes and Risk Management Module (RMM) reports from an identified period, did not identify any documentation related to the above mentioned reported incident by resident #001.

During an interview, the DORC acknowledged the above mentioned information obtained by the inspector from interviews with resident #001 and the staff. The DORC further acknowledged that the reported incident by resident #001 fell under the definition of abuse as defined by the Ontario Regulation (O. Reg.) 79/10. [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 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. 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 has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy titled "Resident's Rights" #RC-2.2 revised in July 2019, under section 2: Abuse policy, indicated that any person (include all staff, volunteers, visitors, or affiliated personnel etc.) who is aware of an incident of abuse and neglect is required to immediately report any and every alleged, suspected, or witnessed, incident of resident abuse and neglect, improper, or incompetent treatment/ care or neglect to the appropriate supervisor in the home (the Director of Resident Care or designate during office hours and the In-Charge Registered Nurse after office hours).

Separate interviews with PSW #100, RN #113, and the BSR Team Lead indicated awareness of the reported incident by resident #001, that resident #002 entered their room, and displayed inappropriate action towards resident #001.

During an interview, the Administrator indicated that in the e-mail communication with resident #001's family on two separate dates, the family indicated resident #001 told them that resident #002 displayed inappropriate action towards resident #001. The Administrator indicated prior to this, they did not hear anything about the incident, and when they had asked the staff after, the Administrator was informed that the staff heard resident #001 claimed that resident #002 displayed inappropriate action towards resident #001. When the staff attended to resident #001 in their bedroom, resident #002 was guided away, and the staff stated they did not see anything that happened, and just settled the situation of the behaviour episode. The Administrator acknowledged that the home's policy on abuse was not complied with by the staff who were made aware of the allegation of abuse, as it was not immediately reported to their appropriate supervisor in the home at the time of the incident. [s. 20. (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 without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #3: 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 immediately forward any written complaints that had been received by the home concerning the care of a resident or the operation of the home, to the Director.

The MLTC received a complaint which indicated that resident #002 entered resident #001's room without their permission and displayed inappropriate action towards resident #001.

A review of the home’s e-mail correspondence with resident #001’s SDM indicated that resident #001 reported to their SDM that a co-resident entered their room several times without their permission. The SDM requested for immediate actions to be taken due to interruptions caused by co-resident #002 to resident #001. On an identified date, the SDM sent another e-mail indicating the RN reported to them that resident #002 went into resident #001’s room and attempted to take their mobility aid. The SDM for the second time, requested for immediate actions to be taken to prevent re-occurrences of resident #002 entering resident #001’s room.

On the first day of the inspection, the inspector requested for the home’s complaints binder for 2020, and the Assistant Administrator (AA) provided the inspector with three printed e-mail correspondences from different Family Members (FMs) regarding concerns about the care and services in the home.

On the last few days of the inspection, the inspector obtained the home’s actual complaints binder, and identified another e-mail correspondence received from a FM, regarding care concerns.

During an interview, the DORC indicated they have worked in the home for about ten months, and they have not forwarded any written complaints they had received, to the Director.

During an interview, the Administrator acknowledged that the above mentioned written complaints were not immediately forwarded to the Director, and further acknowledged that written complaints that had been received by the home, concerning the care of a resident or the operation of the home, should have been immediately forwarded 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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

The MLTC received a complaint which indicated that resident #002 entered resident #001's room without their permission and displayed inappropriate action towards resident #001.

A review of the home’s e-mail correspondence with resident #001’s FM, indicated on an identified date, the FM sent an e-mail to the home’s Administrator, DORC, ADORC, BSR Team Lead, and the SDM, which indicated that disturbances by resident #002 towards resident #001 had happened at least twice in three weeks. The FM expressed their dissatisfaction with the actions taken by the home regarding their concern for resident #001’s safety.

An interview with the Administrator indicated at the beginning of the family’s e-mail communication with the home, the family initially discussed about resident #001’s reaction to resident #002’s entry to their room. When asked by the inspector when and how they were first made aware of the allegation that resident #002 displayed inappropriate action towards resident #001, the Administrator indicated it was in the subsequent e-mail communication with resident #001’s family. The Administrator indicated prior to this, they did not hear anything about the incident, and when they had asked the staff after, the Administrator was informed that the staff heard resident #001 claimed that resident #002 displayed inappropriate action towards resident #001. When the staff attended to resident #001 in their bedroom, resident #002 was guided away, and the staff stated they did not see anything that happened and just settled the situation of the behaviour episode. The Administrator acknowledged that the reported incident by resident #001 was inappropriate and acknowledged it fell under the definition of abuse as defined in O. Reg. 79/10. The Administrator further acknowledged that the alleged incident of abuse of resident #001 by resident #002 was not immediately investigated, and that an investigation procedure should have been started. [s. 23. (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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone, to be implemented voluntarily.

WN #5: 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident, has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A review of the Critical Incident Reports (CIRs) submitted by the home to the Director for an identified period, did not identify that a CIR was submitted for the allegation of abuse of resident #001 by resident #002.

A review of the home's intakes for an identified period, did not identify that an intake was initiated for the allegation of abuse of resident #001 by resident #002. There was no information that identified that the home had called the afterhours pager reporting the allegation of abuse.

During an interview, the Administrator acknowledged they were made aware of resident #001's reported incident that resident #002 displayed inappropriate action towards resident #001. The Administrator further acknowledged the allegation of abuse was not reported to the MLTC, and that it should have been reported once they were made aware of it. [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 #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions.

The MLTC received a complaint which indicated that resident #002 entered resident #001's room without their permission and displayed inappropriate action towards resident #001.

An interview with the complainant indicated on an identified date, resident #001 informed their visiting SDM that co-resident #002 went into their bedroom several times without permission, and that resident #002 displayed inappropriate action towards resident #001.

A review of resident #002’s RAI-MDS assessment indicated they had cognitive impairment.

A review of resident #002’s written plan of care indicated the resident exhibited responsive behaviours and listed out the interventions in place to manage their behaviours.

A review of resident #002’s progress notes for an identified period, indicated five different documentations related to identified interactions between residents #002 and #004 as observed by staff members. Both residents were separated each time it happened.

A review of resident #004's RAI-MDS assessment indicated they had cognitive impairment.

A review of resident #004's written plan of cared indicated resident #004 exhibited responsive behaviours and was at risk of conflict with other residents, and the written plan of care indicated the interventions in place to manage resident #004's behaviours.

An interview with the BSR Team Lead indicated resident #004 had a specified responsive behaviour. The BSR Team Lead reviewed resident #004's written plan of care with the inspector, and acknowledged that interventions were not identified and implemented to address the specified responsive behaviour.

An interview with the DORC acknowledged that resident #004's specified responsive behaviour was known to the staff. The DORC further indicated that when they checked resident #004's written plan of care, there was not much mention of the interventions to address the specified responsive behaviour. The DOC stated the home's expectation for care planning was that the responsive behaviour was documented and interventions were identified and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included:
(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 MLTC received a complaint which indicated that resident #002 entered resident #001's room without their permission and displayed inappropriate action towards resident #001.

A review of the home’s e-mail correspondence with resident #001’s SDM indicated that resident #001 reported to their SDM that a co-resident entered their room several times without their permission. The SDM requested for immediate actions to be taken due to interruptions caused by co-resident #002 to resident #001. On an identified date, the SDM sent another e-mail indicating the RN reported to them that resident #002 went into resident #001’s room and attempted to take their mobility aid. The SDM for the second time, requested for immediate actions to be taken to prevent re-occurrences of resident

#002 entering resident #001's room.

A review of resident #001's progress notes indicated their FM verbalized concerns to RPN #107 on an identified date, and to RPN #105 on three separate dates, regarding safety concerns related to resident #002 entering resident #001's room without their permission.

On the first day of the inspection, the inspector requested for the home's complaints binder for 2020, and the AA provided the inspector with three printed e-mail correspondences from different FMs regarding concerns about the care and services in the home.

On the last few days of the inspection, the inspector obtained the home's actual complaints binder, and identified another e-mail correspondence received from a FM, regarding care concerns.

A review of the home's complaints binder and separate interviews with the SW, DORC, and the Administrator, failed to demonstrate that a documented record was kept in the home that included the required information provided for in the regulation, for the above mentioned verbal and written complaints received by the home. [s. 101. (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 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 in turn by the complainant, to be implemented voluntarily.

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.