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

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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
Aug 16, 2021	2021_887111_0013	006812-21, 010263-21, 010264-21, 010986-21	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

LYNDA BROWN (111)

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): July 20 to 22 and 26, 2021.

There were three follow up inspections and one complaint inspection completed concurrently during this inspection as follows:
-Follow up related to proper positioning during meal times.
-Follow up related to safe medication storage.
-Follow up related to plan of care for falls prevention.
-Complaint related to continence care, food and nutrition care, complaints and missing items.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (a-DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Support Services Supervisor (SSS), Maintenance staff, Physiotherapist (PT), Assistant Administrator (AA) and Housekeepers (HSK).

During the course of the inspection, the inspector(s): toured the home, observed dining service, reviewed resident health records, staffing schedules, complaints, COVID-19 screening records, air temperature logs, reviewed the following policies: missing personal items, preventative maintenance, complaints and Infection Prevention and Control (IPAC) Hand Hygiene.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

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

- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #002	2021_715672_0024	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_882760_0012	111
O.Reg 79/10 s. 73. (1)	CO #001	2021_715672_0024	111

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 O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.2) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1.2).

Findings/Faits saillants :

The licensee has failed to ensure that the heat-related illness prevention and management plan for the home was evaluated and updated, at a minimum, annually in accordance with evidence-based practices.

On May 15, 2021, amendments to LTCHA, under O. Reg. 79/10, related to enhanced cooling requirements came into force. The changes included the following: renaming the written “hot weather-related illness prevention and management plan” to “heat-related illness prevention and management plan”; to implement the plan every year during the period from May 15 to September 15, and on any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day and anytime the temperature in areas of the home in which measurements are required by the Regulation reach 26 degrees Celsius or above, for the remainder of the day and the following day; and was to include a protocol for appropriately communicating the heat-related illness prevention and management plan to residents, staff, volunteers, substitute decision-makers, visitors, the Residents' Council of the home, the Family Council of the home, if any, and others where appropriate. The home’s ‘heat stroke policy’ did not include those required changes or other heat-related illnesses (only for heat stroke). The Administrator and Support Services Manager (SSM) were aware of the new changes to hot weather monitoring policy but had not updated the policy as per the new changes. Failure to implement changes to cooling requirements in the home places the residents at risk for any heat-related illness.

Sources: Heat stroke policy; Amendments to Ontario Regulation 79/10 (Regulation) Under the Long-Term Care Homes Act, 2007 (LTCHA) Related to Enhanced Cooling Requirements, came into force on May 15, 2021 and interview with staff.

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 heat related illness prevention and management plan for the home is evaluated and updated, at a minimum, annually in accordance with evidence-based practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the temperature in the home maintained at a minimum of 22 degrees Celsius (C).

The air temperatures for resident rooms in July 2021 were documented, monitored daily by the Maintenance staff on each unit and there were a number of entries where the air temperatures were below 22 C (ranging from 20-21 C). During June and July 2021, the air temperatures for common areas were monitored in the dining rooms, activation rooms and hallways on each floor and on each unit. On a number of dates, there were temperatures below 22 C (between 19 -21 C). The Maintenance staff indicated that the home had a process for following up on air temperatures that were below 22 C or 26C or higher and had no documented record to indicate actions taken to address the low air temperatures on the identified dates. Failing to ensure that air temperature in the home is maintained at a minimum of 22 C can lead to residents becoming too cold and possible illness.

Sources: resident room temperature checks, air quality monitoring record and interview of staff.

2. The licensee has failed to ensure that the air temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

On May 15, 2021, amendments to the Ontario Regulation 79/10 under the Long Term Care Homes Act, 2007 included enhanced cooling requirements as per evidence based practices. The air temperatures in the home were to be monitored once every morning, every afternoon between 12 and 5 PM and every evening or night in at least two resident rooms and in a common area on every floor. The air temperatures in the home were monitored daily in one resident room and daily in a common area on each floor. The SSM indicated they were aware of the new changes to the legislation but confirmed the air temperature monitoring records and home's policy had not been changed accordingly. There were a number of dates when the air temperature records indicated the temperature was below 22 C and a number of dates when the air temperature was at 26 C. Failing to monitor air temperatures as required can lead to temperatures under 22 C or exceeding 26 C being undetected and lead to residents having either possible heat-related illness or being too cold.

Sources: Preventative Maintenance policy, Air temperature logs and interview with staff.

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 temperature in the home maintained at a minimum of 22 degrees Celsius (C), 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. (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 :

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.

On a specified date, a verbal complaint was received by the home regarding the missing of a personal item for a resident. The verbal complaint had not been resolved as the Administrator confirmed there were ongoing discussions with the family but had no documented record to indicate when the verbal complaint was received, the nature of the complaint, the actions taken to resolve the complaint, the dates when responses were provided to the family, the complainant responses and the final resolution. As a result of the inspection, the Administrator provided the Inspector with a complaint and concern form that provided some of the details related to the complaint. The Administrator confirmed the verbal complaint had not yet been resolved and the family had not yet been provided with a final resolution. Failing to keep a documented record of verbal complaints can lead to unresolved complaints and family dissatisfaction.

Sources: a resident's progress notes, census records, complaint procedure policy, interview with family of a resident and staff.

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 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, 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

The licensee has failed to ensure that there a hand-hygiene program in place and in accordance with evidence-based practices.

The Public Health Ontario-PIDAC “Best Practices for Hand Hygiene in All Health Care Settings indicated that alcohol-based hand rub (ABHR) should be located at point-of-care, the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. In some areas, staff may need to carry ABHR for their own use when it cannot be installed.

During the initial tour of the home, the Inspector observed that their were no point-of care hand hygiene agents-alcohol based hand rub (ABHR) available in a specified unit at resident rooms. There were portable ABHR available at the nursing station, dining room, in three resident rooms that were either on isolation, had a one to one staffing present and on the care carts that were in storage. On a specified date and time, a PSW was observed on the same unit, entering and exiting two different resident rooms without performing hand hygiene. The PSW indicated they were unable to perform hand hygiene as there was no ABHR accessible for their use and they had to go to the nursing station to perform hand hygiene. The IPAC lead (RN #100) confirmed that on the identified unit, there was no ABHR outside of the resident rooms due to an identified risks to residents and verified that the ABHR was only located at the nursing stations, on care carts, dining rooms and lounges. The RN confirmed this did not meet the point-of-care access if the carts were not with the PSW when answering call bells and for visitors. The RN then indicated that the ABHR was not at the resident rooms as the mounting brackets to hold the ABHR was on back order and that the staff were expected to complete hand hygiene by washing their hands at the sink in the residents bathrooms. Failure to ensure that ABHR is accessible to staff and visitors at point-of-care increased the risk of transmission of infections.

Sources: PHO – PIDAC, Best Practices for Hand Hygiene in All Health Care Settings. 4th Edition, April 2014, observations and interview with staff.

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 here a hand-hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, (iv) there is a process to report and locate residents' lost clothing and personal items.

A complaint was received from the family of a resident regarding missing personal items. The family reported on a specified date, specified personal items had been reported missing to both the nurse and the Administrator. The Administrator indicated to the family at that time that they would reimburse the family for the to replace the personal items. The Physiotherapist (PT) confirmed the resident required the use of the personal items for mobility and had gone missing. On a specified date, the family provided the home with the cost of the replacement of the personal items and had not been reimbursed to date. There was no documentation in the resident's health record or an incident report completed regarding the missing personal items as per the homes policy. Failing to implement the policies/procedures for missing personal items can lead to items not being found and complaints.

Sources: complaints, progress notes of a resident, Missing Belongings policy and interviews with staff.

Issued on this 31st day of August, 2021

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

Original report signed by the inspector.