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

Central East Service Area Office
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Original Public Report

Report Issue Date June 15, 2022
Inspection Number 2022_1381_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Mon Sheong Richmond Hill Long-Term Care Centre

Long-Term Care Home and City
Mon Sheong Richmond Hill Long-Term Care Centre, Richmond Hill

Lead Inspector
Lucia Kwok (752)

Additional Inspector(s)
Eric Tang (529)

Inspector Digital Signature
Siu F Tang
2022.08.04 13:59:38 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 4, 5, 6, 9, and 10, 2022.
The following intake(s) were inspected:

Six logs were related to falls.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION – FALLS PREVENTION AND MANAGEMENT

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: s. 49(2) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 54(2) of O. Reg. 246/22 under FLTCHA. The licensee failed to ensure that two residents were assessed using a clinically appropriate assessment instrument after their falls.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 49 (2) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 54 (2) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary
Non-compliance with s. 49(2) of O. Reg. 79/10 under the LTCHA
Two residents had sustained a fall resulting in a significant change in their health status, and their post-fall assessment tools were not fully completed.

The Falls Leads and the Acting Assistant Director of Resident Care (ADORC) confirmed that both residents' post-fall assessments were incomplete and that staff were expected to complete all sections of the post-fall assessment tool.

Non-compliance with s. 54 (2) of O. Reg. 246/22 under the FLTCA
A resident had sustained a fall resulting in a significant change in health status, and their post-fall assessment tool was not fully completed.

The Falls Leads and the Acting ADORC confirmed that the post-fall assessment was incomplete and that staff were expected to complete the post-fall assessment tool in its entirety.

The incompletion of their post-fall assessments posted a risk to the residents and may hinder the staff from identifying the contributing factors to their falls.

Sources: Critical Incident Reports, residents' electronic health records, and staff interviews with the Falls Lead and the Acting ADORC. [529]

WRITTEN NOTIFICATION – DINING AND SNACK SERVICE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg.246/22 s. 79 (1) (10)

The licensee has failed to ensure staff used proper techniques to assist residents with eating.

Rationale and Summary

Inspector #752 observed two different staff providing feeding assistance to two residents while standing up in two different dining rooms. There were empty feeding stools available in the dining rooms for staff to use.

The Director of Resident Care (DORC) stated the expectation was for staff to be seated on the feeding stool when providing feeding assistance.

There was potential safety risk to residents related to choking when staff did not follow proper techniques when providing feeding assistance to residents.

Sources: Observation (May 4, 2022), Interview with DORC. [752]

WRITTEN NOTIFICATION – VISITOR POLICY

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 267 (2) (a)

The licensee has failed to ensure that the visitor logs included the contact information of the visitor.

Rationale and Summary

The Administrator shared that the home had been on a facility-wide COVID-19 outbreak since April 14, 2022, and continued to be on outbreak at the time of the inspection.

During the active screening process on May 4, and 5, 2022, Inspectors #752 and #529 were not asked for their contact information. Inspector #752 observed activation aide #107 conducted active screening of visitors at the home's entrance but they did not ask for the visitor's contact information.

Activation aide #107 shared that they were not advised by their supervisor to collect contact information from visitors during the screening process. The home's visitor's log from April 30 to May 4, 2022, did not document visitor's contact information.

The York Region Public Health Unit (YRPHU) confirmed that the home was to follow MLTC's Directive #3 and COVID-19 guidance document for the minimum requirements for visitors log, which included visitor's contact information.

There was minimal risk to the residents when the home did not collect visitor's contact information.

Sources: Observations (May 4, and 5, 2022); Interview with activation aide #107; home's visitor's log from April 30 to May 4, 2022; Meeting with YRPHU; Directive #3, last revised May 3, 2022, COVID-19 guidance document for long-term care homes in Ontario, last revised April 27, 2022. [752]

WRITTEN NOTIFICATION - HOUSEKEEPING

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 93 (2) (b) iii

The licensee has failed to ensure the implementation of the cleaning and disinfection of contact surfaces was in accordance with evidence-based practices.

Rationale and Summary

The Administrator shared that the home had been in a facility-wide COVID-19 outbreak since April 14, 2022, and continued to be on outbreak at the time of the inspection.

On May 4, 2022, Inspectors #752 and #529 observed housekeeper #105 performed routine cleaning in a resident room.

Housekeeper #105 and Support Services Supervisor shared that inside the resident's room, high touch surfaces included door knobs, bed rails, faucet, side tables, hand rails. The housekeeper stated that they cleaned and disinfected the high touch surfaces in the residents' rooms once daily during outbreak.

The YRPHU confirmed that the home was to follow the Public Health Ontario (PHO) guidance document titled, COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes 5th Revision, last revised November 2021, for the enhanced frequency of cleaning and disinfection of high touch surfaces.

By not increasing the cleaning and disinfecting frequency of high touch surfaces in residents' room during an outbreak, there was actual risk of harm to residents and staff leading to the transmission of infectious agents which included COVID-19.

Sources: Observation (May 4, 2022); Interviews with housekeeper #105 and Support Services Supervisor; Meeting with YRPHU; PHO document, COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes 5th Revision, last revised November 2021. [752]

COMPLIANCE ORDER CO#001 – PLAN OF CARE

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 **s. 6. (7)**

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

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The Licensee has failed to comply with s. 6(7) of the FLTCA.

The licensee shall:

a. Develop and implement a one-time training for the private sitter on the appropriate use of two interventions for a resident and adhering to their appropriate use. This training is to be provided to the private sitter immediately.

b. Keep a documented record of the training provided, including the individual(s) who provided the training, the individual(s) who attended the training and, the date(s) of the training.

c. Develop and implement a monitoring system for the private sitter. Designate a registered staff lead to oversee the implementation of the system. Conduct on-site audits of the monitoring system for a two-week period to ensure that the private sitter is adhering to the training. Analyze audit results and provide re-education/training as needed. Maintain a documented record of the monitoring system and audits conducted.

Grounds

Non-compliance with: FLTCA, 2021, s. 6(7).

The licensee failed to ensure that the resident's interventions were provided as specified in their plan of care.

A resident's care plan stated that they had two interventions in place to ensure their safety. The resident had experienced a fall with an adverse outcome, but the identified interventions were not applied at the time of the incident as per record reviews, and interview with the Private Sitter, Falls Lead, and the Acting Assistant Director of Resident Care (ADORC) confirmed the same. Furthermore, the Falls Lead and the Acting ADORC stated the resident did not receive the interventions as per their plan of care.

There was actual harm to the resident as it resulted in an adverse outcome when their interventions were not implemented.

An order was made by taking the following factors into account:

Severity: There was an actual harm to the resident because they had an adverse outcome after their fall which required hospitalization.

Scope: The scope of this non-compliance was isolated to one resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 6. (7) of the LTCHA. A compliance order was issued on April 23, 2021, that was also related to residents' plan of care and their interventions not implemented.

Sources: Critical Incident Report, the resident's health records, home's security camera footage; interviews with a private sitter, the Falls Lead, and the Acting ADORC.

This order must be complied with by July 15, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty [AMP #001]
Related to Compliance Order [#001]

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$1100.00,** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- CO#001 of Inspection #2021_882760_0012, LTCHA, 2007 s. 6(7)

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

COMPLIANCE ORDER CO#002 INFECTION PREVENTION AND CONTROL PORGRAM

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s.102 (2) (b).

Specifically, the licensee shall:

a. Develop and implement a process to monitor staff and/or family members' adherence to appropriate IPAC measures in relation to Personal Protective Equipment practices for a two-week period. Provide education and training to those staff and/or family members who are not adhering to the appropriate practices. Keep a documented record of the training provided.

b. Develop and implement a process to ensure that expired alcohol-based hand rubs are not in use in the home. Maintain a copy of the process on site.

c. Provide education to housekeeping staff on the process of the collection and processing of soiled reusable gowns as per current best practices. Conduct audits of the housekeeping staff's adherence to the process for a two-week period to ensure their adherence to the process; analyze audit results and to provide re-education as needed. Maintain a documented record of the process and audits on-site

Grounds

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to implement the Infection Prevention and Control standard issued by the Director.

Grounds: In accordance with O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes as of April, 2022, provided additional requirements for IPAC programs in long-term care homes.

The Administrator shared that the home had been on a facility-wide COVID-19 outbreak since April 14, 2022 and continued to be on outbreak at the time of the inspection. They further shared that the Personal Protective Equipment (PPE) requirement in Resident Home Areas and common area without active outbreak was universal masking and eye protection. On May 4, 2022, one resident home area (RHA) remained in active outbreak and was on droplet/contact precautions, as such, full PPE was required inside residents' rooms.

During the inspection, the following observations were noted:
-In two different RHAs, nursing station, and supply room, multiple bottles of expired ABHR or ABHR without expiry date were in use.
-A resident was resting in their bed in their room. The housekeeper conducted routine room cleaning in their room without wearing their eye protection. Housekeeper #106 acknowledged that they should have worn their eye protection while in the resident's room.
-A staff was not wearing eye protection while in a RHA.
-In two different dining rooms, two different staff provided feeding assistance to residents without their eye protection.
-A staff was not wearing their eye protection in the servery.
-A resident room was on droplet and contact precautions, a family member was providing feeding assistance to the resident without their gloves.
-A resident room was on droplet and contact precautions, Inspector #529 observed a visitor without their eye protection.
-In one RHA, a housekeeper was observed to collect bagged soiled gowns from residents rooms and leaving them in piles by cleaned PPE caddies outside of the rooms.

Registered Practical Nurse (RPN) #104 shared that staff were aware some of ABHR were expired and had reported to the home's management team in the beginning of the year. However, the home continued to recirculate the expired ABHR after the previous outbreak. Registered Nurse (RN) #105 stated that all staff were responsible to restock PPE.

The home's policy, Routine Practices and Additional Precautions, IC 3-2.1, last revised July 2021, outlined to handle soiled linen and waste carefully to prevent personal contamination and transfer to other residents.

The IPAC lead shared that home's expectation was for staff to collect soiled reusable gowns with a cart and they should not have piled soiled reusable gowns by cleaned PPE caddies outside of resident's rooms. The IPAC lead/RPN #103 stated that visitors had been provided with IPAC training and the expectation was for staff to monitor and remind visitors if breaches were observed.

The York Region Public Health Unit (YRPHU) confirmed that the home was to follow the Public Health Ontario (PHO) guidance document titled, COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes 5th Revision, last revised November 2022 as part of their outbreak management. Further, the public health unit stated the home should not have used expired ABHR and should have followed the additional precautions in place.

As a result of the facility using expired ABHR and visitors and staff not adhering to the home's PPE requirements, contamination of soiled gown with cleaned PPE, there was actual risk of harm to residents and staff leading to the transmission of infectious agents which included COVID-19.

Sources: Observations (May 4, 5, 2022); Interviews with RPNs #103, #104, Administrator; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), Routine Practices and Additional Precautions policy, IC, 3-2.1, last revised July 2021, Meeting with YRPHU, PHO and MLTC COVID-19 guidance documents. [752]

This order must be complied with by July 15, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.

- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.