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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2014	2014_294555_0028	O-001106-14	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 SCARBOROUGH LONG TERM CARE CENTRE
2030 Mcnicoll Avenue SCARBOROUGH ON M1V 5P4

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

GWEN COLES (555), ANGELE ALBERT-RITCHIE (545), CHANTAL LAFRENIERE (194), MELANIE SARRAZIN (592), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 27, 28, 29, 30, 31, November 3, 4, 5,and 6 2014.

During the course of this inspection two Complaint Inspections were completed concurrently: T-776-14 and T-886-14.

During the course of the inspection, the inspector(s) spoke with Residents, Families, the Administrator, the Director of Resident Care (DRC), Support Services Supervisor, Nutrition Manager, Registered Dietician (RD), Physiotherapist, Chairpersons of the Resident and Family Councils, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide, Dietary Aide, Physiotherapy Assistant, Infection Prevention and Control Lead, and Volunteers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Snack Observation

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

7 WN(s)
4 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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimetres.

It was observed during the Initial Tour of the home on October 27, 2014 at 11:00 that a window located in the third floor Program Room (center window) could be opened more than 15 centimetres. This window overlooked the parking lot and the room was accessible to residents for activities therefore placing residents at risk for falls. The window was brought to the attention of the Director of Resident Care at 11:30 and was observed to be secured to open less than 15 centimetres at 13:00.

It was observed by Inspector #556 on October 28, 2014 at 14:30 that a third floor window in Room S302 was able to be opened greater than 15 centimetres. This window overlooked the home's grounds and was accessible to residents as it was a resident's bedroom, therefore placing residents at risk for falls. The window was brought to the attention of the Director of Resident Care at 14:55 and was observed to be secured to open less than 15 centimetres by Inspector #556 by 16:00.

Interview conducted with the Director of Resident Care on October 29, 2014 at 9:15 who reported all windows have been checked in the home and verified to open less than 15 centimetres. [s. 16.]

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 all windows cannot be opened more than fifteen centimetres, to be implemented voluntarily.

WN #2: 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 ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During an interview on October 30th, 2014, the Residents' Council Chairperson reported that the issues that were brought forward to the Resident Council Meeting were resolved but no responses in writing from the Administrator were ever received.

During an interview with the Activation Supervisor (acting assistant of the President of Residents' Council) he reported that the home is not providing any written response to the Residents' Council unless the home is not able to resolve the concerns or recommendation brought forward by the residents at the Residents' Council meeting. The Activation Supervisor indicated that all issues are solved quickly and therefore there was no need to respond in writing to the Residents' Council.

A review of the Resident Council Minutes for the period of November 2013 to September 2014 was completed. There is no evidence in the Resident Council Meeting binder of any written responses to concerns brought forward by the Council.

During the Resident Council meeting dated May 30, 2014 it is documented concerns related to rushed feeding of residents, the food being salty and greasy, and that the portions of food were too large; and also concerns that with the staff reductions being implemented at the home that medication errors would be an issue. During the Resident Council meeting dated November 13, 2013 concerns related to the number of residents that a sitter could be responsible for and the access to hot water by residents.

During an interview on October 5, 2014 by Inspector #194 the Administrator stated that there was no evidence that a written response to Resident Council had been provided for concerns identified during the meetings on May 30, 2014 and November 13, 2013. [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 responds in writing to the Residents' Council within ten days of receiving concerns or recommendations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response to advice related to concerns or recommendations were provided to the Family Council within 10 days of receiving the information.

Review of the Family Council minutes dated December 2013 identified concerns related to continence products. Review of the Family Council minutes dated June 2014 identified concerns related to staff reductions such as: difficulty finding staff, delay in response to call bells, rushed showers; as well as continence product concerns related to "separation of urine soiled inner layers after two and a half to three hours usage. There is no evidence to support that the Licensee has responded to the Family Council in writing to the concerns within 10 days of receiving the concerns.

The Administrator was not able to provide evidence of written response for concerns identified in the December 2013 and June 25, 2014 meeting. Response to concerns is evident in the following Family Council minutes but no evidence of written correspondence was provided to Family Council within the regulated timelines.

Review of the licensee's Policy "Family Council and Social Worker's Role" PSS-4.16 directs: "The home has a duty to respond in writing to Family Council's concerns or recommendation within 10 days of receiving the advice. [s. 60. (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 responds in writing to the Family Council within ten days of receiving concerns or recommendations, 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 :

1. The licensee has failed to ensure that there is access to point-of-care hand hygiene agents.

During the Resident Quality Inspection in the home it was noted that hand hygiene agent dispensers were located in the corridor fixed to the wall beside the door to each resident room and fixed to the wall above the toilet in each resident bathroom, however no hand hygiene agents were observed inside any of the resident bedrooms.

In an interview the Director of Resident Care (DRC) stated all staff receive training regarding hand hygiene at orientation and annually thereafter. The DRC also stated that PSW staff don't carry personal hand hygiene agent dispensers because there are dispensers along the corridor and one on a mobile care cart, the DRC further stated that the PSW's don't always have the care cart with them when they are entering resident rooms.

Staff #101 was observed by Inspector #556 entering room N306 without the care cart, and in an interview Staff #101 stated that the PSW's don't have the care cart with them every time they enter a resident room. In a separate interview Staff #100 stated that she doesn't carry hand hygiene agent with her but she uses the dispenser on the wall going in and out of resident rooms. [s. 229. (9)]

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 by ensuring that there is 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 8. (1) (b) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system to be complied with, in that the home failed to ensure compliance with the following policy: Audits - Medication Storage and Insulin, Index Number: 06-2-60 (dated: June, 2, 2014).

As per O.Reg 79/10 s. 136 (1) (a) every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs.

As per the home's policy entitled "Audits - Medication Storage and Insulin", Index Number: 06-2-60 (dated: June, 2, 2014), it was documented in item 12: "No expired or discontinued meds in med cart, and item 14: "No expired medications in med room (unless awaiting disposal in a separate location)".

During an observation of the Medication Cart on 2-South on November 5, 2014, Inspector #545 observed one bottle of Biotene Mouthwash, prescribed for Resident #45 - used three times per day before meals with an expiry date of August 2014. When asked, RPN Staff #111 indicated that the bottle should have been discarded as it had expired in August 2014. Staff #111 found 15 bottles of Biotene Mouthwash in the Medication Room with expiry date of August 2014 and would be contacting the family to replace immediately.

During an interview with the DOC on November 5,2014 she indicated that the prescribed Biotene Mouthwash found in the Medication Cart and the 15 bottles of Biotene Mouthwash found in the Medication Room were expired and that they should have been replaced. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the home's furnishings and equipment are kept clean and sanitary.

The home's policy: RC-5.10.10 Mobility Device and Maintenance (Dated: June 2013) indicated that all equipment will be monitored to ensure cleanliness and safety: 1) RN/RPN are responsible to create a cleaning schedule of resident mobility devices to ensure cleanliness, 2) Mobility devices are to be cleaned on a regular basis and whenever visibly soiled, 3) DORC or designate will coordinate annual resident mobility devices cleaning clinic and safety inspection with service provider 4) Staff shall report, detect and record in the maintenance log book located at each nursing station.

During resident observations conducted during Stage 1 of the Resident Quality Inspection (RQI), Long Term Care Homes (LTCH) Inspectors #545 and #555 observed several soiled Residents' ambulation equipment. As a result, Inspector #545 further inspected the ambulation equipment for three Residents on October 30, 2014:
• Resident #10's wheelchair frame was observed dusty and covered with dry debris on the frame as well as debris and white spots on the cushion of the wheelchair.
• Resident #12's Broda-chair was observed dusty and covered with dry white streaks on the blue material of the outside of the seat at the thigh and arm levels and on the table top placed in front of the Resident in the chair.
• Resident #31's wheelchair was observed with sticky debris on the wheels as well as debris and white spots on the seat cushion of the wheelchair.

Upon review of the most recent plan of care, it was documented that Residents #10, #12 and #31 exhibited a behaviour on a daily basis that contributed to the soiling of

equipment.

During an interview with Staff #123 on October 30, 2014 who indicated that it was the responsibility of the PSW to wipe down Resident's ambulation equipment with a wet paper towel and/or disinfecting CaviWipes Towelettes at the time of the Residents bath, twice weekly. Staff #123 indicated that Resident #12's Broda-chair was soiled and was difficult to keep clean due to the Resident's behaviour. Staff #123 indicated that Resident #10's wheelchair was very dirty and found that the wheelchair was very difficult to clean as well. She indicated that Resident #10 received a bath on the morning of October 30, 2014 but that she was not able to clean the wheelchair properly as it was too dirty, and added that she would make arrangement for a deep clean of the wheelchair as soon as possible. Staff #123 indicated that Housekeeping staff clean all ambulation equipment twice yearly using a Wheelchair Washer and that it was the PSW's responsibility to bring the ambulation equipment to the ground floor as per a schedule provided by the Housekeeping Staff. Staff #123 stated that staff were responsible to document in the Unit's Communication Book all wheelchairs requiring extra cleaning.

On October 30, 2014, Inspector #545 observed Resident #31 sitting in a soiled wheelchair in the TV room. The metal frame of the wheelchair was covered with dust and dried debris and the black seat cushion was soiled with sticky debris as well as the wheels of the wheelchair. When asked who's responsibility it was to clean the wheelchairs, Physiotherapist #124 indicated that the wheelchairs in the home were cleaned twice yearly by the housekeeping staff using a set schedule provided to the units. Physiotherapist #124 indicated that the machine used to wash the wheelchairs was like a car-wash, spraying very hot water over the equipment, he then added that the seat cushions were washed by hand. Upon observation of the Wheelchair Washer room, Inspector #545 observed one dining room chair in the Wheelchair Washer machine and two wheelchairs that had been recently cleaned. No other wheelchairs were observed in the Wheelchair Washer room.

Upon review of the Unit's Communication Book for the month of October 2014, notes indicated required cleaning of ambulation equipment for Residents #10, #12 and #31 was not found.

During an interview with Staff #110 on November 5, 2014 who indicated that Residents #10, #12 and #31 exhibited behaviors that make it difficult to keep their ambulation equipment cleaned. Staff #110 also indicated that staff were responsible to clean visibly soiled spots on wheelchairs and other ambulation equipment using a wet towel and/or

CaviWipe to remove any visible body fluid such as sputum. Staff #110 indicated that twice yearly resident's wheelchairs received a deep clean in the Wheelchair Washer as per a set schedule and as needed when requested by staff however the steam cleaning of the wheelchairs had not been completed in a while as the volunteer responsible for this task had been away.

Upon review of the Wheel Chair Cleaning Schedule (dated: March to August 2014) provided by the Support Services Supervisor, it was documented that the ambulation equipment for Resident #10 and #31 received a deep clean by accommodation staff (housekeeping) using the Medco Wheelchair Washer on the following dates:
• Resident #10 using a facility owned wheelchair was scheduled for cleaning: June 19, 2014
• Resident #31 using own wheelchair was scheduled for cleaning: August 7, 2014

The Support Services Supervisor indicated that a different procedure was used to clean Resident's #12's Broda-chair due to size and fabric of the chair, added that she was unsure when it received a deep clean.

During an interview with the Director of Resident Care and the Support Services Supervisor on November 5, 2014, they indicated that in the past the home's ambulation equipment received three deep clean per year: 2 deep clean by the housekeeping staff and a third deep clean by the Home's Mobility Aid Service Provider (Motion Specialties) during the annual safety check. The DRC indicated that in 2014 their Service Provider was unable to provide the cleaning during the safety inspection of the equipment due to lack of manpower. The DRC provided an email dated November 5, 2014 from Motion Specialties indicating they could provide the DRC with the contact information of a cleaning company that provides cleaning of ambulation equipment for clients of Motion Specialties. When asked about the steam cleaning of the wheelchairs, the DRC indicated that the home's assigned volunteer for steam cleaning of the ambulation equipment had been away since July 2014, and that the steam cleaning had not been done since as she was unable to find a replacement for the volunteer. The DRC indicated that the home had not cleaned and sanitized the ambulation equipment belonging to Residents #10, #12 and #31 when they were observed to be visibly soiled. [s. 15. (2) (a)]

WN #7: 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 ensure that it seeks the advice of the Family Council in acting on the results of the satisfaction survey.

Members of the Family Council have stated that the Council is not involved in the results of the satisfaction survey.

Administrator has stated that the Family Council is not involved in the results of the satisfaction survey. [s. 85. (3)]

Issued on this 16th day of December, 2014

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

Gwen Coles #555

Original report signed by the inspector.