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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2017	2016_251512_0017	031357-16	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

TILDA HUI (512), IVY LAM (646)

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): November 9, 10, 14, 15, 16, 17 & 18, 2016

Additional inspection related to the following Log#s was also completed during this inspection: #007429-14 related to fall.

During the course of the inspection, the inspector(s) spoke with the senior administrator, director of resident care (DRC), assistant director of resident care (ADRC), manager of nutrition & dietary services, activation supervisor, registered dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), activation staff, dietary aide (DA), social services coordinator, residents, family members, and substitute decision makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident.

Resident #001 was triggered for inspection by the most recent Minimum Data Set (MDS) assessment to be at a low risk for bladder and bowel incontinence during stage I of the Resident Quality Inspection (RQI).

Review of resident #001's written care plan with an identified date, revealed the resident was described as being incontinent of bladder, the goal was for the resident to remain free from skin breakdown due to incontinence and brief use through the review date. There were interventions set up to address resident's bladder incontinence. Review of the above mentioned care plan did not reveal any focus, goal, and interventions to manage the resident's bowel continence status, and no strategies to address the resident's toileting needs.

During an interview, PSW #108 stated that the resident was incontinent of bladder currently requiring brief changes in bed. PSW #108 indicated the resident was being

toileted before for bladder and bowel elimination prior to his/her recent change in health condition. Since the change, the resident had been staying in bed especially at night receiving brief changes instead of being toileted. During the day, the resident would be returned to bed from the wheelchair for brief change whenever he/she asked to be toileted.

Interview with RPN #109 indicated the resident was incontinent of bladder but continent of bowel. The resident was able to ask to be toileted and staff were providing toileting with assistance. The RPN stated he/she was not aware that there were no strategies set up to address the bowel continence and toileting needs for the resident in the current written plan of care, resulting in unclear directions to some PSW staff.

Interview with the DRC confirmed resident #001's written plan of care did not provide clear directions to direct care staff to enable consistent care delivery to meet the resident's bowel continence and toileting care needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

This inspection was initiated for resident #006 related to No Plan - Low BMI from the staff interview during the RQI.

Review of resident #006's current plan of care revealed the following interventions:
- Ensure resident has appropriate dentures in place when eating,
- Staff assists resident to rinse his/her dentures and put them on in the morning, assists to rinse his/her mouth and clean his/her dentures after each meal. Brush with denture brush at bedtime and immerse in denture solution at bedtime.
- Staff apply his/her upper and lower dentures prior to eating and take off after meals. Brush dentures with denture brush and put the dentures in the denture solution during night time.

Review of resident #006's flow sheet for oral/dentures status in November, 2016, revealed that resident was not provided with dentures.

Observations at mealtimes revealed resident #006 did not wear dentures at mealtimes.

Interviews with PSW #101 and RPN #104 revealed the resident had not been wearing

dentures for the past few months because dentures were not fitting. Interview with RPN #104 revealed the resident was taken for a dental appointment by the family on an identified date, did not return with new dentures, and resident continued not to wear dentures. Interview with RPN #104 further revealed it was the nursing staff who would update the care plan for resident's dental care, and that the care plan for resident #006 was not updated when resident no longer used his/her dentures. Interview with the RD revealed that he/she was unaware that resident no longer wore dentures at mealtimes.

The ADRC and DRC confirmed resident #006's plan of care was not revised when resident's care needs for dental care changed and dentures were no longer used. [s. 6. (10) (b)]

3. This inspection was initiated for resident #004 as triggered during stage I of the RQI by the census record review which revealed a staged pressure ulcer at an identified part of the resident's body.

Review of the resident's current written plan of care with an identified date, revealed the resident has strategies set up to address a pressure ulcer. The focus of the strategies was a pressure ulcer related to requiring extensive assistance in bed mobility. The goal was set that the resident will have intact skin through review date. The interventions directed the staff to administer treatment as ordered and monitor for effectiveness, apply identified protective devices daily to off-load the pressure when up in chair and when in bed, encourage use of bed rails for the resident to assist with turning by two staff every two hours when in bed, keep the resident's bed as flat as tolerated to reduce shear and keep bed sheet free from wrinkles, and monitor/document/report to the attending physician any time when there was changes in the resident's skin status when providing care.

Observation was made on the resident on an identified date during the inspection period, noted the skin on the identified part of the resident's body was intact. The resident was not using any protective devices at the time of observation. The resident was not able to recall when the pressure ulcer was healed.

Interview with PSW #111 indicated the resident's pressure ulcer had healed for the last few months. The resident no longer required the identified protective devices. Interview with RPN #112 indicated the resident no longer required ulcer care and the written plan of care should have been revised to reflect the change.

Interview with the ADRC, lead for the skin and wound program, confirmed resident #004's written plan of care should have been revised to reflect the resident's pressure ulcer had healed, and that interventions for pressure ulcer care were no longer necessary. [s. 6. (10) (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 the plan of care set out clear directions to staff and others who provide direct care to residents, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Review of the Home's policy, NPS 9.2, 'Others - Care of Nail Clipper,' revised July 2016, revealed:
Each nail clipper shall be identified with resident's name and room number, and be kept

in a safe area by nursing staff. In the Procedure section, it was stated that only use nail clipper that labelled with resident’s name and ensure nail clipper is labelled with resident’s name before storage.

Observations made during the RQI of the residents’ nail clipper storage in the spa room on two identified units revealed multiple nail clippers that were only labelled with residents’ room numbers but not residents’ names. The Inspector observed for one identified resident room, the name on the nail clipper did not match the name of the current resident residing in the identified room. And one nail clipper did not have any resident’s name nor room number on it. There were 11 nail clippers noted to be labelled with identified resident’s room numbers and not residents’ names.

Interview with PSW #114 revealed the nail clipper of a former resident who had passed away was still stored in the same nail clipper slot of the current resident living in the identified room.

Interviews with PSW #114, #120, and RPN #121 revealed the PSWs on each resident unit were responsible for labelling resident’s nail clippers. Interviews with PSW #110 and #114 further revealed when a new resident moved into a room, the nail clipper of the former resident should be discarded. Interviews with the ADRC and DRC confirmed the staff did not participate in the implementation of the infection prevention and control program by labelling resident’s nail clippers with the residents' names and room numbers. [s. 8. (1)]

2. This inspection was initiated related to a staff interview at stage I revealed resident #002 was using an urinary apparatus .

Review of the home's policy titled Continence Care and Bowel Management Program, policy number RC-4.6, revision date July 2016, stated in the Procedure section that the RN/RPN shall conduct a Continence Assessment using the Point-Click-Care (PCC) program titled Assessment after any change in a resident's condition that may affect the resident's bladder and bowel continence functions. The assessment shall include identification of contributing factors, patterns, type of incontinence, medications and potential to restore function and type and frequency of physical assistance necessary to facilitate toileting.

Review of resident #002's current written plan of care with an identified date, revealed the resident had a urinary apparatus in use. Review of the Minimum Data Set (MDS)

assessment dated 28 months earlier on admission, indicated the resident was described to be continent of bladder and bowel. The MDS assessment dated 12 months after admission, revealed significant change in the resident's continence status to usually continent of bowel and frequently incontinent of bladder. The MDS assessment dated 18 months after admission, revealed a second significant change in the resident's continent status to totally incontinent of both bladder and bowel.

Interviews with PSW #128 and RPN #126 indicated the resident did experience deterioration during the two above mentioned periods of time. RPN #126 reviewed the list of assessments conducted on the resident and indicated a Continence Assessment at the PCC program under Assessment was not conducted for the resident after each of the two changes in condition.

Interview with the DRC confirmed the comprehensive continence assessment should have been conducted on the resident after the identification of the two deterioration of continence status of the resident in accordance to the home's policy. [s. 8. (1) (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 the home's policies on continence care and bowel management program and the care and labelling of residents' personal care equipment including nail clippers put in place are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was triggered from the staff interview for resident #002 during stage I of the RQI for a pressure ulcer.

Review of resident #002's current written care plan with an identified date, revealed the resident experienced a pressure ulcer. The goal was to prevent the wound from infection and complications. The interventions directed staff to perform wound assessment weekly to monitor effectiveness of wound treatment.

Review of the list of wound assessments conducted on resident #002 revealed the wound assessments were not conducted weekly on 17 identified dates.

Interviews with RPN #126 indicated wound assessment was supposed to be conducted on resident #002 weekly. The RPN stated however the pressure ulcer could be healed one day and re-open the next day.

Interview with ADRC #127, the skin and wound lead, confirmed registered nursing staff

were expected to conduct weekly wound assessment on residents with any stage of a pressure ulcer. The ADRC stated wound assessments should have been conducted weekly on resident #002 as long as a pressure ulcer was present. [s. 50. (2) (b) (iv)]

2. This inspection was initiated for resident #004 as triggered at stage I of the RQI by the census record review of a pressure ulcer.

Review of the resident's current written plan of care with an identified date revealed the resident has strategies set up to address a pressure ulcer. There were focus, goal and interventions developed to manage the resident's pressure ulcer.

Review of the resident's list of wound assessments conducted on the resident revealed wound assessments were not conducted weekly on 10 identified dates since the identification of the pressure ulcer on the resident.

Interview with RPN #112 indicated the resident was identified with a pressure ulcer for the past seven months, and weekly wound assessment should be conducted on the resident until the pressure ulcer was assessed to be healed seven months later. RPN #112 could not recall why the weekly assessment was not conducted on the resident during the above mentioned periods.

Interview with ADRC, the skin and wound program lead, confirmed the home's practise was to conduct weekly wound assessment on residents with pressure ulcer. The ADRC indicated weekly wound assessment should have been conducted for resident #004 for the pressure ulcer until the ulcer healed. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation of the medication cart was made on an identified date during the inspection period, on an identified unit in the medication room. Non-drug related items were found in the narcotic cupboard including:
-One key with label for vaccine fridge
-One change purse with a note on the outside indicating resident's name and $35.

Interview with RPN #112 indicated the above mentioned non-drug related items were in the narcotic cupboard for safe storage. RPN stated he/she was aware the narcotic cupboard was for narcotic medications storage only. The RPN proceeded to relocate the non-drug related items into one of the locked cupboard in the medication room.

Interview with the DRC confirmed non-drug related items should not be kept in the narcotic cupboard of the medication cart. [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to be afforded privacy in treatment and in caring for his/her personal needs was fully respected and promoted.

Observation made during the RQI revealed PSW #102 clipping resident #022's finger nails outside the nursing station on an identified unit in the hallway, while another resident was sitting at the nursing station.

Review of the home's policy, numbered NPS 4.2.7. titled 'Activities of Daily living – Hygiene – Nail care "Care of Nail Clipper – Others' revealed: Nail care may be performed either in the tub room, or in the resident's room. Each resident will have his/her own labelled nail clipper to prevent cross contamination. In the Procedure section, it stated Assemble required equipment in area where procedure is to be conducted. Ensure privacy.

Interviews with RPN #123, the ADRC and DRC revealed it was the home's expectation for staff to assist with residents' nail care in the residents' room or in the spa room. The ADRC and DRC further confirmed that resident #022 was not provided with privacy when staff provided nail care to the resident. [s. 3. (1) 8.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

This inspection was initiated related to a staff interview at stage I revealed resident #002 had an urinary apparatus in use.

Review of resident #002's current written plan of care with an identified date, revealed the resident had an urinary apparatus in use. Review of the Minimum Data Set (MDS) assessment on admission dated 28 months earlier, indicated the resident was described to be continent of bladder and bowel. The MDS assessment dated 12 months after admission, revealed significant change in the resident's continence status to usually continent of bowel and frequently incontinent of bladder. The MDS assessment dated 18 months after admission, revealed a second significant change in the resident's continent status to totally incontinent of both bladder and bowel.

Interviews with PSW #128 and RPN #126 indicated the resident did experience deterioration during the two above mentioned periods of time. RPN #126 reviewed the list of assessments conducted on the resident and indicated a Continence Assessment at the PCC program under Assessment was not conducted for the resident after each of the two changes in condition.

Interview with the DRC confirmed the comprehensive continence assessment should have been conducted on the resident after the identification of the two deterioration of continence status of the resident. [s. 51. (2) (a)]

WN #7: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program by labelling residents' personal care equipment in shared washroom.

Observation made on an identified date during the inspection on an identified unit in an identified resident's room noted unlabelled personal care equipment in shared washroom including one denture cup and two toothbrushes on the counter. There were two unlabelled toothbrushes and a denture cup also on the other side of the counter.

Interviewed with PSW #103 indicated the personal care equipment should be labelled. Interview with the DRC indicated staff were expected to label all residents' personal care equipment upon admission and when additional items were brought in. [s. 229. (4)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program by labelling individual nail clipper with resident's name and room number for residents' use.

Observations made during the RQI of the residents' nail clipper storage in the spa rooms on two identified units revealed multiple nail clippers that were only labelled with residents' room numbers but not residents' names. The Inspector observed for an identified residents' room, the name on the nail clipper did not match the name of the current resident residing in the identified room. There were 11 nail clippers noted to be labelled with identified resident's room numbers and not residents' names.

Interview with PSW #114 revealed the nail clipper of a former resident who had passed away was still stored in the same nail clipper slot of the current resident living in a second identified room.

Interviews with PSW #114, #120, and RPN #121 revealed the PSWs on each resident unit were responsible for labelling resident's nail clippers. Interviews with PSW #110 and 114 further revealed when a new resident moved into a room, the nail clipper of the former resident should be discarded. Interviews with the ADRC and DRC confirmed the staff did not comply with the home's policy regarding care and labelling of resident's nail clippers. [s. 229. (4)]

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Issued on this 24th day of January, 2017

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

Original report signed by the inspector.