Ontario

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

Inspection Report under the
***Fixing Long-Term Care Act, 2021***

**Central East Service Area Office**
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

**Original Public Report**

**Report Issue Date** September 12, 2022
**Inspection Number** 2022_1636_0001
**Inspection Type**
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☒ Post-occupancy
☐ Other _____

**Licensee**
Mon Sheong Foundation

**Long-Term Care Home and City**
Mon Sheong Stouffville Long-Term Care Centre - Stouffville

**Lead Inspector**
Sami Jarour (570)

**Additional Inspector(s)**
Sarah Lee (735818) and Britney Bartley (732787)

**Inspector Digital Signature**
Sami Jarour
Digitally signed by Sami Jarour
Date: 2022.09.26 11:22:07 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): August 2-5, 8-12, 2022

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Resident Care and Support Services
- Residents' and Family Councils
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

## INSPECTION RESULTS

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

**Central East Service Area Office**
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## NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)**

O. Reg. 246/22 s. 265.(1)10

On August 2, 2022, the required information related to the home's visitor policy was not posted in the home.

On August 4, 2022, the Social Services Coordinator (SSC) confirmed that the current visitor policy was not posted in the home. The SSC indicated they will post the policy right away.

On August 4, 2022, the policy was posted in the home on the ground floor.

**Sources:** Inspector #570's observations and interview with Social Services Coordinator.

Date Remedy Implemented: August 4, 2022. [570]

## WRITTEN NOTIFICATION - RECORDS

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

**Non-compliance with: O. Reg. 246/22 s.278. (1)**

The licensee has failed to ensure that a record is kept for each staff member of the home.

**Rationale and Summary**

According to FLTCA, 2021, s.2(1) "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party

Mon Sheong Stouffville Long-Term Care Centre had 320 licensed beds in ten residents' home areas. The staffing schedule for the month of August 2022 indicated the home was staffed by two staffing agencies. Each staffing agency provided staffing on regular basis for direct resident care in five residents' home areas.

The Administrator indicated that staff records for staff employed by Mon Sheong were kept onsite at the home including human resources (HR) interviews; employment agreements, police records, vaccinations, Tuberculosis (TB) testing, and proof of license/certification.

Agency's staff records were not kept at the home. The records were kept at the agency's office except for the roster of names and the work schedule; other records including police records, vaccinations, work permits, training records were kept at the agency's offices. If any document was needed, the staffing agencies were notified, and the requested records would be provided.

Failing to keep staff records onsite at the LTC home would limit the LTC home's ability to verify staff credentials and qualifications to provide direct care to residents putting residents at risk of harm.

**Sources:** Staffing schedule for August 2022, Interview with Administrator. [570]

## WRITTEN NOTIFICATION - REPORTING AND COMPLAINTS

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

**Non-compliance with: FLTCA, 2021 s.28(1)**

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident may have occurred shall immediately report the suspicion and the information upon which it is based to the Director.

**Rationale and Summary**

A review of a resident's progress notes on Point Click Care (PCC) revealed that they requested to speak to a supervisor regarding a staff who provided care to them. The resident reported to the Resident Care Lead (RCL) #116 that the staff was unkind and did not provide a required intervention to them.

The resident indicated they felt scared and reported the incident to the supervisor.

RCL #116 indicated that the incident was not reported as they spoke to both the resident and PSW #117 and that there was no suspicion of abuse or neglect.

The Administrator indicated that the incident should have been immediately reported when RCL #116 became aware of it.

Failing to report allegations or suspicions of abuse or neglect could potentially put residents at increased risk of further incidents of abuse or neglect.

**Sources:** Progress notes for the resident, interviews with the resident, Resident Care Lead #116 and the Administrator. [570]

## WRITTEN NOTIFICATION - RESIDENTS' BILL OF RIGHTS

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

**Non-compliance with: FLTCA, 2021 s. 3(1)1**

The licensee has failed to ensure a resident's rights to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, was respected and promoted.

**Rationale and Summary**

A review of a resident's progress notes on Point Click Care (PCC) revealed that the resident reported to the Resident Care Lead (RCL) #116 that a staff was unkind to them, did not provide them with an intervention and spoke to them about personal concerns related to COVID-19.

The resident indicated they felt scared and reported the incident to the supervisor.

RCL #116 indicated that they spoke to PSW #117 and explained to them that it was not the resident's concern to be spoken to about personal concerns and educated the PSW to wear proper personal protective equipment (PPE) when caring for residents with COVID-19.

The Administrator indicated that it was inappropriate for PSW #117 to speak to the resident about personal concerns related to COVID-19.

The resident was not treated with respect and dignity when they were spoken to by PSW #117 regarding personal concerns related to COVID-19.

**Sources:** Progress notes for the resident, interviews with the resident, Resident Care Lead #116 and the Administrator. [570]

## WRITTEN NOTIFICATION – DINING AND SNACK SERVICES

**NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with O. Reg. 246/22 s.79 (2)b**

The licensee has failed to ensure that residents who required assistance with eating and drinking, were not served their meal until someone was available to provide the assistance required by the resident.

**Rationale and Summary:**

During a meal observation, a resident was served their meal with no assistance provided when the meal was served. The resident was served with dessert while their meal remained in front of them with no assistance provided until PSW #112 came and assisted the resident with their meal and started with the dessert. PSW #112 left the resident for approximately five minutes and returned to continue feeding the resident the dessert while standing next to the resident.

During a meal observation, another resident had their meal in front of them on the dining room table with no assistance provided until eight minutes later.

PSW #112 indicated that they saw the resident sitting and went to feed them as no one was helping them and they did not know how long the plate was in front of the resident. PSW #112 indicated they fed the resident the dessert while standing as there was no chair available.

The Manager of Nutrition and Dietary Services and the Administrator indicated that meals were to be served when assistance was available for feeding.

By not assisting residents when meals are served could pose a risk of poor food and fluid intake, decreased enjoyment of the meal and possible contamination of the food or fluid items.

**Sources:** Observations of meal service; interviews with PSW #112, The Manager of Nutrition and Dietary Services and the Administrator. [570]

## WRITTEN NOTIFICATION – DINING AND SNACK SERVICES

**NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with O. Reg. 246/22 s. 79(1)9**

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist three residents who required assistance with eating.

**Rationale and Summary:**

During a meal observation, a staff member and PSW #112 were observed to be standing when assisting two different residents with their meals. A family member was feeding another resident while standing in front of them.

PSW #112 indicated they fed the resident while standing as there were no chairs available.

The Dietitian (RD) and the Manager of Nutrition and Dietary Services indicated that staff should be seated to maintain eye level with residents when feeding residents to avoid aspiration and choking risks.

Failing to use proper techniques while feeding residents could put residents at risk of aspiration and choking.

**Sources:** Observations of meals service; interviews with PSW #112, Manager of Nutrition and Dietary Services and RD. [570]

## WRITTEN NOTIFICATION - PLAN OF CARE

**NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

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

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary:**

During a meal observation, PSW #102 served a resident with thickened fluids. PSW #102 indicated that the resident was on thickened fluids.

The resident's written care plan directed to provide regular fluids and to serve diet as ordered.

The RD indicated that the resident was not on any thickened fluids and that staff should follow the care plan and the diet book. If a resident was on regular fluids, they should not have thickened fluid.

Failing to provide care as directed in the care plan specific to diet orders could put residents at risk of poor intake.

**Sources:** Observation of meal service; The resident's written care plan; interviews with PSW #102 and RD. [570]

## WRITTEN NOTIFICATION - COMMUNICATION AND RESPONSE SYSTEM

**NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 20(f)**

The licensee has failed to ensure that the resident-staff communication and response system clearly indicated, when activated, where the signal was coming from.

**Rationale and Summary**

The licensee's resident-staff communication and response system was designed to include the use of a portable phone to alert staff when and where an activation station (nurse call bell) was activated by a resident, staff, or visitor.

PSWs #102, #103, #104, and #105 did not have their portable phones on them when they were requested to produce them while on shift. The Director of Resident Care (DORC) confirmed that staff must carry their phones at all times during their shift unless they are sitting at the nursing station where the display screen can be seen.

There was a potential risk to residents when the staff did not carry their phones as they would not have a timely method to determine which residents were requesting assistance.

**Sources:** Observations in resident home areas, staff interviews, interview with DORC. [735818]

## COMPLIANCE ORDER [CO#001] - MAINTENANCE SERVICES

**NC#009 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: O. Reg. 246/22 s. 96 (2) (k).

**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. 96 (2) (k).

Specifically, the Licensee shall:

1. Retrain and educate staff who are responsible for monitoring hot water temperatures in the home (including how often the temperature will be monitored and how the temperature will be documented). Document the date of the education provided, the name of the person who provided the education, and the names of the staff who have completed the education. Make this information available to inspectors upon request.

2. Conduct weekly audits for one month of the home's process to ensure that the procedures for monitoring hot water temperatures are being complied with (including how often the temperature will be monitored and how the temperature will be documented). Document the audit date, the audit results, and the name of the staff who conducted the audit. Make this information available to inspectors upon request.

3. Develop a process for how the home will ensure the responsibilities for monitoring hot water temperatures are delegated when those who normally carry out these functions are not available.

**Grounds**

**Non-compliance with: O. Reg. 246/22 s. 96 (2) (k).**

The licensee has failed to ensure that procedures were implemented to monitor the water temperature once per shift in random locations where residents had access to hot water when a computerized system to monitor the hot water was not in use.

**Rationale and Summary**

According to the home's Hot Water Temperature Policy, RC – 5.16 last revised July 2022, water temperature should be tested every shift at different locations in the home where residents have access to hot water. The licensee does not have a computerized water monitoring system. The hot water temperature was to be taken three times each day (once in the morning, once in the afternoon, and once in the evening). The Director of Resident Care (DORC) identified that there were gaps in the transition of responsibilities when the Home Area Assistant (HAA), who were responsible for taking the hot water temperatures, were not available. The home's Daily Hot Water Temperature Form for June and July on two units) were missing hot water temperature monitoring records for many shifts on several days.

There was a potential risk of scalding to residents due to staff not implementing their hot water monitoring procedures.

**Sources:** Daily Hot Water Temperature Forms, interview with DORC, Hot Water Temperature Policy (RC-5.16; revised July 2022). [735818]

**This order must be complied with by** November 11, 2022

## COMPLIANCE ORDER [CO#002] – MAINTENANCE SERVICES

**NC#010 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: O. Reg. 246/22 s. 96 (2) (h)

**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. 96 (2) (h).

Specifically, the Licensee shall:

1. Retrain and educate staff who are responsible for reporting, documenting, and responding to hot water temperature exceedances to ensure that immediate action is taken. Document the date of the education provided, the name of the person who provided the education,

and the names of the staff who have completed the education. Make this documentation available to inspectors upon request.

2. Conduct weekly audits for one month of the home's process to ensure that the home's procedures for reporting, documenting, and responding to hot water temperature exceedances are being complied with. Document the audit date, the audit results, and the name of the staff who conducted the audit. Make this documentation information available to inspectors upon request.

## Grounds

**Non-compliance with: O. Reg. 246/22 s. 96 (2) (h)**

The licensee has failed to ensure that procedures were implemented to ensure that immediate action was taken when the water temperature exceeded 49 degrees Celsius.

**Rationale and Summary**

According to the home's Hot Water Temperature Policy, RC – 5.16, last revised July 2022, all readings outside the normal range of 40 to 49 degrees Celsius must be reported to the Support Services Supervisor or designate, and all necessary corrective actions must be taken and documented by the Support Services Supervisor.

According to the home's process when the water temperature exceeded 49 degrees Celsius, staff were to inform maintenance through the maintenance log located on each unit. When maintenance staff were notified of a hot water temperature exceedance, they were to reduce the hot water temperatures and to document the action taken.

For the hot water temperature exceedances recorded on June 1, 2, 3, 7, 9, and 10 for one unit and on July 23, 25, and 26 for another unit, no records of maintenance notification or maintenance services were completed. No immediate action was taken to reduce the water temperature when it exceeded 49 degrees Celsius.

There was a potential risk of scalding to residents due to staff not implementing their hot water monitoring procedures to ensure immediate action was taken when the water temperature exceeded 49 degrees Celsius.

**Sources:** Interviews with DORC, Manager of Building Services, and Supervisor of Building Services, Daily Water Temperature Monitoring Form, Maintenance Daily Request Checklist, Maintenance Spreadsheet, Maintenance Requests, Hot Water Temperature Policy, RC-5.16 last revised July 2022. [735818]

**This order must be complied with by** November 11, 2022

## COMPLIANCE ORDER [CO#003] - INFECTION PREVENTION AND CONTROL PROGRAM

**NC#011 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:

1. Educate PSW #108, PSW #109, and RPN#110 on the appropriate selection, application, removal, and disposal of personal protective equipment (PPE). Document the components of the education provided, the date of the education provided, the name of the person who provided the education, and the names of the staff who have completed the education. Make this information available to inspectors upon request.

2. Complete daily PPE audits related to the selection, application, removal, and disposal of PPE on two residents' home areas for two weeks. The PPE audits must be started after the education component, as per requirement (1) above, has been provided. Document the audit date, the audit results, the name of the staff who conducted the audit, and what, if any, on-the-spot education was provided to staff related to appropriate PPE practices. Analyze the audit results and educate staff who are not in compliance. Make this information available to inspectors upon request.

**Grounds**

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

The licensee has failed to ensure to implement any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee did not ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal, were followed

in the IPAC program as required by Additional Requirement 9.1 Additional Precautions (f) under the IPAC Standard.

**Rationale and Summary**

According to the IPAC Lead, all staff were required to wear an N95 mask and to follow droplet and contact precautions when providing care inside all resident rooms in the confirmed outbreak areas.

The following items related to PPE selection, application, removal, and disposal were observed on August 2 and 3, 2022 in confirmed outbreak areas:

- While doffing their PPE outside a resident's room, PSW #108 changed their mask while still wearing a face shield. PSW #108 did not clean and disinfect their face shield when leaving the resident's room. PSW #108 and the IPAC Lead confirmed that the face shield was to be removed prior to changing their mask and that staff were to clean and disinfect their face shield when leaving resident rooms.
- PSW #109 donned an isolation gown while already wearing gloves and proceeded to enter a resident's room with a medical mask and a face shield on. When leaving the resident room, PSW #109 did not change their mask or clean and disinfect their face shield. PSW #109 confirmed that they improperly donned their gown and gloves. PSW #109 stated that they can wear medical masks since they were providing care for a resident who was not positive for COVID-19 in the confirmed outbreak areas. The IPAC lead confirmed that staff were to put on their isolation gowns prior to donning gloves, staff were to clean and disinfect their face shield upon leaving resident rooms in outbreak areas, and staff were to wear an N95 mask and follow droplet and contact precautions in all resident rooms in outbreak areas.
- Registered Practical Nurse (RPN) #110 left a resident's room without doffing their isolation gown and proceeded to enter a second resident's room with the same gown on. RPN #110 did not have any eye protection when entering the resident rooms. The IPAC lead confirmed that staff were to wear eye protection in the resident rooms and that staff were to put on a new gown before they entered a resident's room and doff their gown when leaving the resident's room.
- Multiple staff were observed wearing a N95 mask under a medical mask in the hallways of resident home areas. A PSW was observed wearing a N95 mask under a medical mask while feeding a resident in their room. The IPAC lead stated that wearing a N95 mask under a medical mask was not permitted in the home for staff or visitors.

These observations demonstrated that there were inconsistent PPE practices conducted by the staff. By conducting improper PPE selection, application, removal, and disposal, there was a risk of the transmission of infectious agents including COVID-19 to residents and staff, during a confirmed COVID-19 outbreak.

**Sources:** Observations (PPE donning and doffing practices), interviews with staff and IPAC Lead, Routine Practices and Additional Precautions Policies, IC-3.2.1 and IC-3.2.2 last revised July 2021. [735818]

**Ministry of Long-Term Care**
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**This order must be complied with by** November 11, 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.