Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1636-0003	
Inspection Type: Complaint, Follow up, Critical Incident System **Licensee:** Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville	
Lead Inspector Britney Bartley (732787)	**Inspector Digital Signature**
Additional Inspector(s) Fatemeh Heydarimoghari (742649) Amandeep Bhela (746) Julie Dunn (706026)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

January 3, 4, 5, 6, 9, 10, 11, 13, 16, 17, 18, 19, 2023

The following intake(s) were inspected:

- Two intakes related to alleged staff to resident neglect.
- One intake related to unknown cause of injury to a resident.
- One intake related to medication incident.
- Four intakes related to responsive behaviours.
- Two intakes related staff to resident physical abuse.
- One intake related to the unexpected death of a resident.
- Eight intakes related to falls which resulted in significant change in health status.
- One complaint intake regarding a significant change in a resident's health status.
- Follow up to CO #001 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 96 (2) (k).
- Follow up to CO #002 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 96 (2) (h).
- Follow up to CO #003 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 102 (2) (b).

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance:

Order #001 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 96 (2) (k) was inspected by Britney Bartley (732787).

Order #002 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 96 (2) (h) was inspected by Britney Bartley (732787).

Order #003 from Inspection #2022_1636_0001 related to O. Reg. 246/22 s. 102 (2) (b) was inspected by Fatemeh Heydarimoghari (742649).

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

Pain Management
Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect
Infection Prevention and Control
Falls Prevention and Management
Staffing, Training and Care Standards
Housekeeping, Laundry and Maintenance Services
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (b)

1) The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

Rationale and Summary

In accordance with the IPAC Standard for Long Term Care Homes (LTCH's), revised April 2022, section 9.1 (b) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Specifically, the licensee did not ensure that a Personal Support Worker (PSW) performed hand hygiene when exiting a room on additional precautions.

A PSW was observed exiting a resident room that was placed on additional precautions. The PSW opened the door, removed their gloves and gown, and exited the room without performing hand hygiene.

The IPAC lead and the PSW confirmed it was the expectation for them to perform hand hygiene after doffing personal protective equipment (PPE) to minimize the transmission of infectious diseases.

Failure to perform hand hygiene increased the risk of transmission of infectious disease.

Sources: IPAC Standard for LTCH's April 2022, observation, interviews with a PSW and the IPAC lead. [746]

Non-compliance with: Reg 246/22 s.102 (2). IPAC Standard Section 9.1 (d)
2) The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

Rationale and Summary

In accordance with the IPAC Standard for LTCH's, revised April 2022, section 9.1 states the licensee shall ensure that additional precautions are followed in the IPAC program that includes: d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

A PSW was observed exiting a resident room on additional precautions. The PSW opened the door, removed their gloves and gown, and exited the room without cleaning and disinfecting their face shield, changing their N95 mask and performing hand hygiene.

A Registered Practical Nurse (RPN) was observed sitting at the nursing station with their face mask below their nose, other staff were in proximity. The RPN acknowledged that they wore their face mask incorrectly.

The IPAC lead confirmed when providing direct care to a resident, staff are to clean and disinfect their face shield, change their mask, and perform hand hygiene after exiting a room placed on additional precaution. All staff are required to wear face masks to cover their nose and mouth.

By staff not following the proper use of donning and doffing their PPE, increased the risk of transmission of infectious disease.

Sources: IPAC Standard for LTCH's, revised April 2022, observations, and interviews with staff.

[746] [742649]

Non-compliance with: Reg 246/22 s.102 (2). IPAC Standard Section 6.1

3) The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, revised April 2022.

Rationale and Summary

In accordance with the IPAC Standard for LTCH's, revised April 2022, section 6.1, states that the licensee shall make PPE available and accessible to all staff and residents, appropriate to their role and level of risk. This shall include having a PPE bin to ensure adequate access to PPE supplies for routine practices and additional precautions.

It was observed that a resident had an additional precaution signage posted at the entrance of their room. The PPE bin was not supplied with disinfectant wipes, N95 face masks and face shields. The resident's clinical record confirmed they were on additional precaution.

The IPAC lead confirmed that the PPE bin for the resident should have all PPE supplies, such as N95 face masks, face shields and disinfectant wipes.

By failing to ensure PPE supplies were accessible at point of care puts the residents at potential risk of transmission of infectious disease.

Sources: Observation and interview with the IPAC lead.

[742649]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out, clear directions to staff and others who provide direct care to the resident regarding the use of a device.

Rationale and Summary

A Critical Incident System (CIS) Report was submitted to the Director relating to a significant change in a resident's health status. During the inspection, a resident was observed to have a device applied to their body while seated. Instructions entered in the home's documentation system outlined specific safety instructions staff were to follow when the device was in use. Two direct care staff indicated they did not receive any instruction or direction regarding the device. A registered staff acknowledged that they did not provide any instruction regarding the use of the device to the two staff.

Failing to provide clear direction to direct care staff regarding the use of a device poses a moderate risk to the resident.

Sources: Resident's clinical records, observations, interviews with staff.

[706026]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (1)

The licensee failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Rationale and Summary
A CIS report was submitted to the Director related to a medication incident. A review of a resident's clinical records and the home's internal investigation notes indicated that they received a medication that was not ordered for them. An RPN indicated that during the medication administration process,

they had called out a resident's name, and in response the resident nonverbally consented, and they proceeded with administering the medication. The RPN further indicated they failed to check the resident's name identifier before administrating the medication. The RPN and Assistant Director of Resident Care (ADORC) acknowledged that failure to check the resident's identifier prior to the administration resulted in the medication incident.

Failure to ensure that the medication was administered to the correct resident, put the resident at potential risk for associated adverse reactions.

Sources: A resident's clinical records, LTCH's internal investigation notes and interviews with staff.

[746]

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary

A CIS report was submitted to the Director, alleging a resident did not receive their scheduled bath. The resident required assistance with bathing and was scheduled for showers on specific dates.

A PSW was aware the resident required a shower on a specific date and stated they did not provide the shower. The PSW also did not inform the charge nurse, so other arrangements could be made. Another PSW assumed the resident was given a shower and signed the documentation. The Director of Care (DOC) confirmed the LTCH's expectations was the resident should be showered at minimum, twice weekly in the method of their choice.

In failing to ensure the resident was showered twice weekly, there is low risk to the resident.

Sources: A resident's clinical records, LTCH's internal investigation notes, interviews with staff.

[706026]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee failed to ensure that a resident's safety device was applied as set out in their plan of care.

Rationale and Summary

A CIS report was submitted to the Director for an incident that resulted in significant change in a resident's health status. During the inspection, a resident was observed sitting in their mobility device without a safety device applied. A PSW and two RPNs indicated that they had not applied the safety device for the resident as per their plan of care.

The resident's plan of care indicated that they were at risk for injury and a safety device was to be applied when the resident was in their mobility device.

The ADORC acknowledged the safety device should be applied when the resident was using their mobility device.

As a result of this, the resident was put at risk, as staff may not be able to prevent the resident from injury in a timely manner.

Sources: A resident's clinical records, observation, interviews with staff.

[746]

2) The licensee 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

A CIS report was submitted to the Director for a fall incident that occurred with a resident. A review of

the resident's assessment stated they were at risk for injury. In addition, the resident's plan of care identified the resident was to have an intervention in place for fall prevention.

The home's internal investigation notes indicated the intervention was not done as per the resident's plan of care. A PSW on duty did not follow the intervention and left the resident alone. In the absence of the intervention, a RPN found the resident in their bedroom where the incident occurred.

The ADORC and an RPN confirmed the intervention was not followed and the PSW should have followed the plan of care.

As a result of the home not following the resident's plan of care, an incident occurred.

Sources: A resident's clinical record, the home's internal investigation notes, email communication and interviews with staff.

[742649]

WRITTEN NOTIFICATION: Requirements Related to Restraining by a Physical Device

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (6)

The licensee failed to ensure that no physical device was applied under section 35 of the Act to restrain a resident while in bed.

Rationale and Summary:

A CIS report was submitted to the Director, related to an incident that resulted in a significant change in a resident's health status. Instructions found in the home's documentation system directed staff to apply a specific type of device on the resident while in bed. A PSW indicated that when they provided care to the resident in bed, the device was applied to minimize risk of injuring the resident. The ADOC confirmed the device was used in the home.

In failing to ensure that no physical device was applied under section 35 of the Act to restrain the resident while in bed, there was moderate risk to the resident.

Sources: A resident's clinical records and interviews with staff.

[706026]

WRITTEN NOTIFICATION: Maintenance Services

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

The home was previously issued a Compliance Order related to O. Reg. 246/22 s. 96 (2) (h) with a compliance due date of November 11, 2022. The home was found to be in compliance with the order, however, after the compliance due date, the home was no longer taking immediate action when the water temperature exceeded 49 degrees Celsius.

As per 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 charge nurse, the maintenance designate on duty and documented in the maintenance book. Once the maintenance staff were notified of a hot water temperature exceedance, they were to reduce the hot water temperatures.

On January 1 and 2, 2023, the hot water temperature exceeded 49 degrees Celsius on two resident units. No records of maintenance notification were completed. A PSW confirmed they documented the hot water temperature above 49 degrees Celsius on January 2, 2023, and took no immediate action to reduce the water temperature.

The Administrator was informed of the exceeded hot water temperatures and confirmed PSWs were to inform the charge nurse, maintenance designate on duty and document in the logbook.

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: Daily water temperature monitoring form, maintenance spreadsheet, Hot Water Temperature Policy, RC-5.16 last revised July 2022, interviews with staff.

[732787]

WRITTEN NOTIFICATION: Maintenance Services

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

The home was previously issued a Compliance Order related to O. Reg. 246/22 s. 96 (2) (k) with a compliance due date of November 11, 2022. The home was found to be in compliance with the order, however after the compliance due date the home was no longer checking the hot water temperature as required.

As per the home's Hot Water Temperature Policy, RC 5.16, last revised July 2022, the water temperature should be tested every shift at different locations in the home where residents have access to hot water. The hot water temperature was to be taken three times each day.

A review of the home's hot water temperature logs from December 1, 2022, to January 3, 2023, there was a total of 58 missing logs for four resident units. In addition, the inspector was unable to locate January 2023 logs two other resident units. On January 3, 2023, a PSW from a unit confirmed they were unable to locate the January 2023 log sheet for a resident unit and could not confirm if the temperature was taken for that day.

The Administrator was informed of the undocumented hot water temperature logs and the missing January 2023 log sheets for two resident units. The administrator confirmed the home's current process of checking the hot water temperature was not effective and planned to evaluate the process.

By the home not consistently checking the hot water temperature there was a potential risk of scalding to residents.

Sources: Daily Hot Water Temperature Forms, Hot Water Temperature Policy RC-5.16; revised July 2022, interviews with staff.

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[732787]

COMPLIANCE ORDER CO #001 Falls Prevention and Management

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The licensee has failed to comply with O. Reg. 246/22, s. 54 (2)

Specifically, the Licensee shall:

1. Retrain RNs and RPNs, including agency staff who are responsible for initiating and completing a Neurological Observation Chart. Document the date of 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 Neurological Observation Chart is initiated and completed as per the home's Fall Prevention and Management Program. Make this information available to inspectors upon request.

Grounds

Non-compliance with: O. Reg 246/22, s. 54 (2)

The licensee failed to ensure that the Fall Prevention and Management Program policy was complied with for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that any policy put in place must be complied with. Specifically, the licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

A review of the home's policy titled, Fall Prevention and Management Program, dated July 2022, indicated that registered staff are to initiate a required assessment and complete as per protocol for any unwitnessed fall or if injury is suspected. The required assessment should be completed even if the resident is asleep.

The required assessment indicates that it must be done for 24 hours post fall:

Assessment every 1 to 2 hours for the first 2 hours
Assessment every hour for the next 4 hours
Assessment every 4 hours for the next 12 hours

A review of a resident's clinical records, video footage and investigation notes indicated that on a specific date and time the resident sustained an unwitnessed incident. They were found by a staff member and sustained no injuries. Later that day, a PSW was assisting the resident in their mobility device and discovered that the resident was deceased.

Video footage was reviewed on a specific date and time. The resident was observed seated in their mobility device near the entrance of an area. No registered staff were observed during this time completing the required assessment for the resident.

A required assessment was not completed in its entirety at two specific times leading up the resident's passing. The ADORC acknowledged that the home's policy was not complied with and further indicated that this was a serious matter as the resident had sustained an unwitnessed incident.

Failure to complete the required assessment, put the resident at risk as there could be delay in identifying any health changes or injuries as a result of the incident.

Sources: A resident's clinical records, video footage, LTCH's internal investigation notes and interview with staff.

[746]

This order must be complied with by May 19, 2023

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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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.