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

Original Public Report

Report Issue Date: October 5, 2023	
Inspection Number: 2023-1636-0005	
Inspection Type: Critical Incident Follow up	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville	
Lead Inspector Natalie Jubian (000744)	**Inspector Digital Signature**
Additional Inspector(s) Jacqueline Smith (000740) Carole Ma (741725) Moses Neelam (762)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28 to 31 and September 1, 5 to 8, 2023.

The following intake(s) were inspected:

- Intake related to a complaint regarding improper care.
- Intake related to a complaint regarding multiple care items.
- Intakes related to alleged resident-to-resident abuse.
- Intake #00021750 – First Follow-up to Compliance Order #001 from Inspection #2023_1636_0003 - O. Reg. 246/22 - s. 54 (2) related to Falls Prevention and Management, Compliance Due Date (CDD) May 19, 2023.
- Intake related to alleged staff to resident abuse.
- Intake related to resident neglect.
- The following intakes were completed in this inspection: Intakes related to resident fall with injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1636-0003 related to O. Reg. 246/22, s. 54 (2) inspected by Natalie Jubian (000744)

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Reporting and Complaints
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that staff complied with the Long-Term Care Home’s (LTCH) written policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

The LTCH submitted a Critical Incident Report (CIR) to the Director on a certain day. The day before, a resident reported to a team member that a staff had a negative interaction with them.

The Assistant Director of Care (ADOC) indicated the incident occurred on a weekend and the Charge Nurse (CN) working that day was new to the home. They confirmed that the CN should have but did not call the Ministry of Long Term Care's (MLTC's) after hours phone number to immediately report the alleged resident abuse.

The home's Abuse Policy indicated that incidents of alleged abuse needed to be reported immediately to the Director and that after hours, the CN was designated to do this by using the MLTC's after-hours phone number.

There was no risk to the resident with failing to ensure the Director was notified immediately.

Sources: LTCH's Abuse Policy, interview with ADOC. [741725]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE – LICENSEE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee failed to ensure that a written complaint from a Substitute Decision-Maker (SDM) concerning the care of a resident and a change in staff assignment, was immediately forwarded to the Director in the manner set out in the regulations.

Rationale and Summary

The LTCH submitted a CIR to the Director, related to a written complaint made by a resident's SDM to the home.

The Social Services Coordinator (SSC) spoke with the SDM on a certain day. During this telephone conversation, the SDM raised some concerns related to documentation of the resident's recent care, and a change to Personal Support Worker (PSW) assignments. The SSC maintained that during the conversation, the SDM clearly denied they were voicing a complaint, and maintained were advocating for improvements in the home for the benefit of other residents.

The SDM emailed the SSC two times, detailing some of the issues raised, posed multiple questions, and wrote they were writing for the purpose of the LTCH's investigation and information. The SSC forwarded the emails to the Administrator. On the same day, the Administrator sent an email to the Acting Assistant Director of Resident Care ((A)ADORC) and included the Acting Director of Resident Care ((A)DORC) in the carbon copy. The Administrator specifically referred to the SDM's concerns as a complaint that, would need to be looked into by the (A)DORC upon their return to work.

The (A)ADORC confirmed the home did not submit a CIR immediately upon receiving the written complaint.

Failing to immediately inform the Director of this complaint posed no risk to the resident.

Sources: resident's clinical records, Email correspondences from SDM and staff, Interviews with staff. [741725]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee failed to ensure that all hazardous substances in the home are labelled properly and are always kept inaccessible to residents.

Rationale and Summary

During an Infection Prevention and Control (IPAC) tour, an unlabeled bottle and peroxide bottle were observed sitting on the top of an unattended housekeeper's cart. Additionally, two residents were observed in the hallway adjacent to the housekeeper's cart.

The Product Specification Document for Peroxide Multi Surface Disinfectant and Cleaner outlined precautions as "Corrosive. Concentrate causes irreversible eye damage and skin burns. Harmful if swallowed or absorbed through skin. May be fatal if inhaled."

The housekeeper supervisor indicated chemicals were not suppose to be left on top of carts but locked away at the bottom.

The Administrator and Support Services Team Lead indicated that peroxide is a hazardous substance and should not be left unlocked on the housekeeper's cart. Additionally, the Administrator stated this poses a potential high risk to residents.

Failing to ensure hazardous substances are kept locked and inaccessible to residents posed a safety risk to residents, as peroxide is corrosive, harmful if swallowed or absorbed through skin and may be fatal if inhaled.

Sources: Observations, Interviews with staff. [000740]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE: LICENSEE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 107

The licensee has failed to ensure that the written procedures required under clause 26 (1) (a) of the Act incorporate the requirements set out in section 108 of this Regulation between April 11, 2022, until July 2022

Rationale and Summary

A complaint was made to the LTCH regarding a resident care issue that alleged harm to the resident due to an action of a staff member. The LTCH's policy on complaint was resolved during the time of the

incident. The policy at the time of the incident, was not updated until July 2022. Specifically, the requirement to provide the complainant with the information for the Ministry's complaint line and the ombudsman contact information in a response was not noted. Ontario Regulation 246/22, from April 11, to July 10, 2022, required that this information be included in the LTCH's procedures for complaints. The LTCH's procedures from July 2022, onwards required the home to inform the complainant in the response of the Ministry's complaint line and ombudsman contact information.

The (A)DORC indicated that the policy did not require for the LTCH to notify the complainant about the Ministry's complaint line and ombudsman contact information.

As result of these procedures not being updated there was a risk of the LTCH not providing the complainant required information. However, there was no risk to the resident.

Sources: Policy's revised on July 2021 and July 2022, and Interview with ((A)DORC) [762]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

1. The licensee failed to include in their response to the complainant on April 13, 2022, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A complaint was made to the LTCH regarding a resident care issue that alleged harm to the resident due to an action of a staff member.

The issue was resolved the same day by the (A)DORC, however, there was no mention of the response including information about the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010. In an interview, the (A)DORC, indicated that the information for the ministry and ombudsman was not provided during this complaint response, but is generally provided at admission and posted in the home.

As a result of this, there was no risk to resident, however, could have potentially prevented the complainant from raising the issue further, if they were not satisfied with the response of the LTCH.

Sources: Progress notes and Interview with (A)DORC. [762]

2. The licensee has failed to ensure that a response letter to the complainant included the Ministry's toll-free telephone number for making complaints and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

The LTCH received a written complaint regarding resident care issues. A review of the complaint and the home's response by the ADORC and the COO (Chief Operation Officer) of the home's staffing agency, indicated none of the response emails to the complainant included the Ministry's toll-free telephone number for making complaints about homes, nor the hours of service and contact information for the patient ombudsman.

The ADORC acknowledged that the response email to the complainant did not include the Ministry's toll-free telephone number for making complaints about homes nor the hours of service and contact information for the patient ombudsman.

Failure to include the Ministry's toll-free telephone number for making complaints and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010, the complainant would be unable to forward their complaints to someone outside of the long-term care home to have their complaints heard and validated.

Sources: Complaint email, LTCH's response, and interview with the ADORC. [000744]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that a documented record was kept in the home that included every date on which any response was provided to a resident's SDM with respect to a complaint, and a description of the response.

Rationale and Summary

The home submitted a CIR to the Director related to a written complaint made by a resident's SDM.

A review of the LTCH's records indicated the SDM emailed the SSC two times, for the purpose of providing information for the home's investigation, related to multiple areas of concern. The SSC forwarded the emails to the Administrator on the same day. In response, the Administrator emailed the (A)ADORC and included the (A)DORC in the carbon copy, specifically referring to the SDM's concerns as a complaint, that would need to be looked into by the (A)DORC upon their return to work.

In two separate interviews, both the (A)ADORC and the (A)DORC indicated they had multiple phone calls together with the SDM, however, were not able to recall the dates and did not document all conversations. The (A)DORC was able to produce brief notes from one conversation, however, it was not dated. The (A)ADORC recalled that the SDM was not satisfied with the outcome of the investigation, however the (A)DORC recalled that the SDM was satisfied and appreciative. The (A)DORC acknowledged the investigation notes, including responses to the SDM were not all in one place and dated, and that the home could have been more organized in managing this complaint. As a result, the (A)DORC was not able to provide the inspector with every date on which any response was provided to the complainant and a description of the response.

In failing to keep a documented record of the responses made to the SDM that included every date and a description of the response itself, the home neglected to follow its own complaints process, which resulted in inaccuracies in recalling the complainant's acceptance of the investigation findings and a loss of transparency in how the home resolves complaints.

Sources: Resident’s clinical records, email correspondences from SDM and staff, Handwritten note by (A)DORC, Interviews with staff. [741725]

WRITTEN NOTIFICATION: ADDITIONAL REQUIREMENTS, s. 26 OF THE ACT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)

The licensee failed to ensure a complaint was forwarded immediately to the Director when a complaint alleged harm or risk of harm, including, but not limited to, physical harm, to a resident.

Rationale and Summary

A complaint was made to the LTCH regarding a resident care issue that alleged harm to a resident due to an action of a staff member. The complainant was submitted to the Director six days after the complaint was made to the LTCH.

An interview the (A)DORC indicated that at the time of the incident, they did not think the email alleged harm, but a few days later decided to submit it. Furthermore, they indicated this should have been submitted to the Director the same day.

As a result of the late submission to the director, there was no risk to the resident.

Sources: Email from complainant and Interview with (A)DORC. [762]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #008 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 comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee is ordered to comply with the following:

1. Ensure PSWs #116, #119, #121 and #122 are provided education on the home's policy on the four moments of hand hygiene, tested on the policy and ensure their scores are above 80 percent.

2. Ensure the IPAC Lead or management designate conduct weekly hand hygiene audits on specific resident home areas (RHAs) for at least one meal service and one snack service each, for three weeks, to ensure that the four moments of hand hygiene are being complied with. During the audits, the IPAC Lead or designate will provide on-the-spot education as needed.

3. During the audits, ensure the alcohol-based hand rub (ABHR) bottles used during meal service and snack service, and any bottles in use for residents on droplet contact precautions all provide a clearly printed expiry date.

4. Keep a documented record of the following:
-All staff who have been tested on the home's policy on the four moments of hand hygiene, that includes a copy of the policy, date policy was reviewed and staff full name and signature and the test and the score results.
-All hand hygiene audits that includes the date, time and location of the audit and the name of the person conducting the audit.
-All on-the-spot education that includes the name of persons providing and receiving education, the date of the provided education and content of the education.
-All ABHR bottles removed due to an illegible expiry date that includes the date, time, location.

5. Make records available for Inspectors upon request.

Grounds

The licensee failed to ensure that any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee did not ensure that PSWs #116, #119, #121, and #122 performed hand hygiene prior to and after resident contact.

1) In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated 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).

Rationale and Summary

During an IPAC tour, PSW #119 and PSW #116 on different units were observed assisting residents with snacks without performing hand hygiene in-between resident contact. The following day, during a mealtime observation in the dining room, PSW #121 removed the masks of three residents without performing hand hygiene prior to and after each resident contact. In the same observation, PSW #122 moved a chair over to a resident and did not complete hand hygiene prior to making contact with another resident.

PSWs #116, #119, #121, and #122 acknowledged failing to complete the four moments of hand hygiene during the observed interactions with residents. The IPAC lead confirmed failing to complete the four moments of hand hygiene did not meet the LTCH's IPAC expectations and was a risk of increasing the risk of infection to residents.

By failing to ensure hand hygiene was completed in between resident contact, residents were placed at risk for transmission of infection, including COVID-19.

Sources: Observations, interviews with PSWs #116, #119, #121 and #122, and IPAC lead. [000740] [741725]

2) In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, section 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 percent Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90 percent ABHR.

Rationale and Summary

During an IPAC tour on a specific location, two bottles of ABHR were found without an expiry date. The ABHR was used to clean resident and staff hands during meal service. Another bottle of ABHR was found without an expiry date, outside of a certain room. The resident was isolated on droplet contact precautions at the time, and the unit was on a COVID-19 outbreak.

The IPAC lead indicated that they were aware of the issue and acknowledged that the expiry dates easily rubbed off the bottom of these bottles. Furthermore, the IPAC lead confirmed the ABHR in those bottles may have expired and therefore could be less effective if used when conducting hand hygiene.

By failing to ensure an expiry date was printed onto each bottle of ABHR, the home may have supplied expired ABHR for use, which placed residents at risk for transmission of infection, including COVID-19.

Sources: Observations, interview with IPAC lead. [741725]

This order must be complied with by November 17, 2023.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
Prior non-compliance with O. Reg. s. 102 (2) (b), resulting in Compliance Order (CO) #003 from inspection #2022_1636_0001, issued on September 12, 2022.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.