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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Dec 22, 2015	2015_252513_0024	034227-15	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 HOME FOR THE AGED
36 D'ARCY STREET TORONTO ON M5T 1J7

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

JUDITH HART (513), ARIEL JONES (566), TIINA TRALMAN (162)

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): December 10, 15, 16, 17, 18 and 21, 2015.

During the course of the inspection, the inspector(s) spoke with residents and families, Residents' Council president, Family Council president, personal support workers (PSW), registered nursing staff, support services supervisor, physiotherapist, dietary supervisor and registered dietitian (RD).

During the course of the inspection, the inspectors toured the home, observed resident care, medication administration, meal and snack service, reviewed resident health records, Council meeting minutes, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

On December 17, 2015, the inspector observed staff #118 administer medications on the second floor. After the medications were removed from the medication pouches, the pouches were placed in a clear bag located on the medication cart. Following medication administration, this bag was tied with a knot and placed in the general trash in the medication room, for removal to the general trash bins of the home. The medication pouch contained personal health information (PHI) including the resident's name, room number, date and time for medication administration, medication name, prescription number and quantity. This information was intact and visible on the discarded pouch, which was verified by staff #100 and #118.

An interview with registered staff #100 revealed a memo had been sent by pharmacy to cut the resident's name and room number from the medication pouch and place it in water to denature the information from the medication pouch, destroying the PHI. He/she confirmed in this case, process had not been followed and the residents' PHI was not removed.

An interview with the Administrator confirmed that every resident has the right to have his or her personal health information kept confidential in accordance with the Act, and in this instance the residents' PHI was not kept confidential. [s. 3. (1) 11. iv.]

WN #2: 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 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.

A record review of resident #006's most recent minimum data set (MDS) resident assessment instrument (RAI) and care plan revealed the resident is frequently incontinent of bladder, wears a medium-sized brief, and is on a scheduled toileting program to help manage and maintain continence. Further review of the resident's clinical record failed to reveal the presence of a continence assessment tool that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, since the resident's admission three years prior.

An interview with registered staff #104 confirmed resident #006 is frequently incontinent of bladder and has been since his/her admission. He/she revealed the home uses an electronic "continence assessment" tool to assess residents' continence, and was unable to locate a continence assessment for resident #006.

Interviews with registered staff #100 and the Administrator confirmed the home has a cumulative continence assessment tool to assess residents' continence, an expectation all residents receive a continence assessment on admission and with a change in continence level, and that resident #006 should have received a continence assessment on admission. [s. 51. (2) (a)]

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.