Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 21, 2020	2020_595110_0011	017199-20	Complaint

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 Richmond Hill Long Term Care Centre
11199 Yonge Street RICHMOND HILL ON L4S 1L2

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

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 24, 28. September 4, 15, 18, 21-23, 2020.

A Critical Incident System report related to the same issues of improper nutrition and hydration care, improper medication monitoring, lack of respect for sleep preference were inspected during this complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physician, Manager of Nutrition and Dietary Services, Social Worker, Registered Dietitian, Activation Supervisor, Registered Nurse, Registered Practical Nurse, Dietary Aide, Personal Support Worker, Removal Technician, Substitute Decision Maker.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **7 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	Légende 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Over a 21 week period resident #001 was identified at hydration risk and consistently not meeting their targeted fluid goals. Registered nursing staff were unaware of the resident's targeted fluid goals, intake shortfalls and health conditions were not assessed as possible signs and symptoms of dehydration. The resident's plan of care failed to include an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, specifically the resident's plan of care did not identify the resident's hydration status and hydration risks.

Sources: Progress notes, PCC Look Back Report Fluids Intake from , blood work, Registered Dietitian assessments, written care plan. Staff interviews RNs #108, #116, #124, RD #113 and the DOC. [s. 26. (3) 14.]

2. Over an 18 week period resident #006 was identified at hydration risk and consistently not meeting their targeted fluid goals. Registered nursing staff were unaware of the resident's targeted fluid goals, intake shortfalls and a health condition was not assessed

as a possible sign and symptom of dehydration. The resident's plan of care failed to include an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, specifically the resident's plan of care did not identify the resident's hydration status and hydration risks.

Sources: Progress notes, PCC Look Back Report Fluids Intake, Registered Dietitian assessments, written care plan. Staff interviews PSWs #119, RN #124, RD #113 and the DOC. [s. 26. (3) 14.]

3. The licensee has failed to ensure that the plan of care based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that resident #001 was not placed to bed after meals for a nap as requested and often very tired.

Staff interviews revealed the resident was often placed in the TV lounge after meals and that the plan of care would direct staff otherwise.

The resident's plan of care did not include an interdisciplinary assessment of the resident's sleep patterns and preferences.

Sources: written plan of care, progress notes, interviews with resident #001's SDM, DOC, PSWs #103, #105, #111, #112 and RN #114. [s. 26. (3) 21.]

4. A tour of the home area was conducted with a RPN and identified residents #002 and #003 in bed at approximately 1440hrs. A review of both resident's plans of care failed to identify an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

Sources: plan of care, resident observations, interview with RPN #101, DOC. [s. 26. (3) 21.]

5. The licensee failed to ensure the registered dietitian, who is a member of the staff of the home, assessed the resident's hydration status, and any risks related to hydration.

Resident #001 was admitted and determined to require a targeted fluid goal daily by the RD. Over a subsequent five month period resident #001 was identified with hydration

risks and consistently not meeting their targeted fluid goals.

Ongoing documentation by the RD included notes that the resident's intake was below their goal and for staff to continue to encourage the resident to drink. The RD failed to assess the resident's risk to their hydration, specifically access to preferred fluids, access to adequate fluids or other barriers to drinking.

Sources: progress notes, PCC look back fluids intake report, blood work, Registered Dietitian assessments, written care plan. Staff interviews RD #113. [s. 26. (4) (a),s. 26. (4) (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 the plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine are supported and individualized to promote comfort, rest and sleep.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that resident #001 was not placed to bed after meals for a nap as requested.

An admission note included documentation that the resident required rest periods during the day. Documentation one month later revealed the resident fell attempting to self transfer themselves to bed to sleep after lunch.

Five months later a note identified the resident's SDM requesting the resident be placed in bed for napping after lunch and to get up before dinner. A review of the resident's written plan of care failed to include the resident's sleep patterns and preferences.

Interviews with staff #110 shared that resident #001 liked to sleep and would sit down and fall asleep. PSWs #103, #105, #111 shared that the resident stayed up in a wheelchair during the day shift, the routine was to be taken to breakfast, placed in the TV lounge, taken to lunch and back to the TV lounge.

An interview with RN #114 stated that only in special cases are a resident's sleep patterns and preferences included in a resident's plan of care.

Sources: Admission assessment. Progress notes. Written plan of care. Interviews with SDM, DOC, RN #114, PSWs #110, #112, #103 and #105 and other staff. [s. 41.]

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's desired bedtime and rest routine are supported and individualized to promote comfort, rest and sleep, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure there a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Resident #001 when admitted was assessed by the RD to require a targeted fluid goal daily.

PSW staff monitor fluid intake by way of documenting milliliters (mls) taken at meals and snacks.

Over a 24 week period the resident’s fluid intake consistently did not meet their estimated fluid requirement. The resident had possible signs and symptoms of dehydration. Registered nursing staff did not evaluate the fluid intake records of residents with identified risks to hydration.

Sources: Progress notes, PCC look back fluids intake report, blood work, Registered Dietitian assessments, Written care plan for resident #001. Staff interviews, PSW #122, RN #108, RN staff #116 RD #113 and DOC #115. [s. 68. (2) (d)]

2. Resident #006 was determined to require a targeted fluid goal daily by the RD.

Over an eighteen week period, the resident's fluid intake consistently did not meet their estimated fluid requirement. The resident had possible signs and symptoms of dehydration that were not assessed. Registered nursing staff did not evaluate the fluid intake records of residents with identified risks to hydration.

Sources: Progress notes, PCC look back fluids intake report, Registered Dietitian assessments, written care plan. Staff interviews PSWs #119, RN #124, #116 RD #113 and the DOC. [s. 68. (2) (d)]

3. The licensee failed to ensure a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that resident #001 lost significant weight during their five months in the LTC home and was not made aware of the resident's significant weight loss after admission. Weight summary sheet's identified the resident's admission weight followed by a significant weight loss and ongoing weight loss. Interviews and record review revealed that the resident's weight was not taken on admission but transcribed from an admission document.

Sources: Admission document entitled Personal Health Profile, Weight Summary report and monthly body weight document. Staff interviews, PSW #112, #103, RPN #107 and the DOC #115. [s. 68. (2) (e) (ii)]

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 there a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee had failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, a change of 5 per cent of body weight, or more, over one month, 7.5 per cent of body weight, or more, over three months, 10 per cent of body weight, or more over 6 months or any other weight change that compromises their health status.

Resident #001's weight summary report identified their weight and a subsequent weight which represented a significant weight loss over one month.

Record reviews and staff interviews failed to identify an interdisciplinary assessment of the resident's weight loss. The physician and registered dietitian were not notified of the resident's significant weight change, who are part of the interdisciplinary team approach. The RPN/RN failed to analyze and investigate, developing appropriate interventions with the multidisciplinary care team, resident and/or SDM according to the home's policy when a resident demonstrates a weight gain/ loss 5% in one month.

Sources: Progress notes, weight summary report and monthly unit 'body weight' document. Physician #117's round communication book from the unit. Policy -Intake and Output monitoring. Staff interviews RPN, 101, RN, #108, #114, physician #117, RD #113 and DOC #115. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, a change of 5 per cent of body weight, or more, over one month, 7.5 per cent of body weight, or more, over three months, 10 per cent of body weight, or more over 6 months or any other weight change that compromises their health status, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee failed to ensure an individualized menu was developed for the resident if their needs cannot be met through the home’s menu cycle.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that resident #001 lost weight during their time in the LTC home.

Resident #001 lost weight and demonstrated a poor food and fluid intake.

The admission nutrition documentation identified the resident's food preferences. The SDM confirmed the resident's preference.

Interviews with PSWs #111, #112, #103, RPN #107 and dietary aide #120 shared an awareness of the resident’s poor intake. PSW #112 stated the resident was picky and the food served in the home was ‘no oil or salt’. The Manager of nutrition and dietary services identified the menu was a no added salt diet and the food might be a bit bland for some but condiments like soya sauce, ketchup were available.

Dietary Aide #120 who served the resident was aware of the resident’s poor intake but unaware of the documented admission preferences of the resident. The dietary aide stated their was no individualized menu developed for the resident.

The home's policy directed staff to consider the provision of an alternate menu plan to improve the resident's nutrition status when determining if a unplanned weight change including 5% over 1 month is related to nutrition factors.

The RD confirmed the resident’s nutritional needs were not met through the home’s menu cycle and the home’s menu was lower in sodium. The resident was provided with nutritional supplements but an individualized menu had not been provided or considered.

Sources: Initial nutritional assessment, nutrition and dietary services communication book, progress notes, interviews with SDM, PSWs #111, #112, #103, RPN #107, dietary aide #120, manager of nutrition and dietary services #121 and RD #113. Policy - Weight Monitoring, revised date July 2019. Look back report related to food/fluid intake. [s. 71. (5)]

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 an individualized menu was developed for the resident if their needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Over a five month period resident #001 had a medication order, in that the medication was to be administered daily if the resident's health condition was as stated. Staff did not comply with the directions for use as the medication was given daily without the resident's health condition being assessed.

Sources: Medication administration records, progress notes, vital records sheets, interviews with RN #116, DOC #115 and physician #117. [s. 131. (2)]

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 administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that resident #001's health condition was not being monitored in the home until the SDM raised attention.

Resident #001 record indicated the monitoring of resident's #001's health condition and then a four month period of no monitoring while the resident's health condition changed.

RN #116 and DOC #115 identified that the initial monitoring of resident #001's health condition should have been reported to the physician to trigger a review of the resident's medication and that resident's health condition should have been monitored more frequently.

Months later documentation revealed that the resident's SDM requested the physician to reassess the resident's medication, which resulted in the resident's medication being decreased. [s. 134. (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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #8: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respected their dignity, was fully respected and promoted.

Resident #001's SDM brought forward a concern to the Ministry of Long Term Care. The SDM shared that on the day resident #001 passed away family were present at the resident's bedside and the resident was not dressed in a respectful manner. Staff confirmed the manner in which the resident was dressed. The resident's plan of care did not identify this as a dressing preference while in bed. Interviews with RPN #101, PSW #111 and DOC #115 identified the staff placement of resident #001's clothes, had not fully respect the resident and their right to be treated with courtesy.

Sources: written plan of care and interviews with the SDM, PSW #105, #111, removal technician from Dignity Memorial #102, RPN #101 and DOC. [s. 3. (1) 1.]

Issued on this 22nd day of October, 2020

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

Original report signed by the inspector.