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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 10, 2021	2021_715672_0003	023716-20, 000403-21	Critical Incident System

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 14, 15 and 18, 2021

The following intakes were completed during this inspection:

One intake related to an alleged incident of staff to resident abuse.
One intake related to a COVID-19 outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator, Associate Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nutritional Services Manager and dietary aides, Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Pain Management, Prevention of Abuse and Neglect and Responsive Behaviours. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 was free from abuse by the staff in the home.

For the purposes of the Act and Regulation, “Neglect” is defined as:

“the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.” O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an incident involving resident #009. According to the CIR, resident #009 was receiving a bath on the a specified date, when the resident began to exhibit identified responsive behaviours. Following the bath the resident was noted to have an injury and was complaining of pain. A specified assessment was completed on an identified date, which diagnosed resident #009 with an injury.

Record review indicated that resident #009 had responsive behaviours, with interventions listed for staff members to implement as required. Progress notes indicated the physician had been notified on on a specified date, of the observed injury and they ordered a specified assessment. Between an identified period of time, the resident had documented complaints of pain, exhibited non-verbal signs of pain and was guarding the injured body part which had visible injuries noted. There was no follow up regarding when the specified assessment would be completed between an identified period of time, nor was the physician notified of the delay in having the test completed, resident #009’s visible injuries or ongoing complaints of pain.

During separate interviews, PSWs #109 and #110 indicated they were bathing the resident when the resident began to exhibit identified responsive behaviours. PSWs #109 and #110 further indicated they continued to provide care to the resident after the resident began to exhibit identified responsive behaviours and were unaware of how the injury to the resident occurred.

During an interview, RPN #111 indicated they had not followed up and were not aware of any other staff member following up regarding when the specified assessment would be completed between an identified period of time. RPN #111 also did not believe the physician had been notified of the delay in having the assessment completed and had

not considered transferring resident #009 to the hospital for further assessment due to concerns related to the pandemic.

During an interview, the Assistant Administrator indicated the expectation in the home was for staff to follow up with the provider and notify the physician if an ordered test had not been completed within the expected 24 to 48 hours. The Assistant Administrator further indicated they were unaware of how the injuries to resident #009 had occurred, as they had not interviewed staff members following the incident, they had only requested staff statements. The staff statements indicated staff were unaware of how the injuries occurred.

By not ensuring that staff followed up on resident #009's injury within the expected 24 to 48 hours, there was no follow up for an identified period of time to determine the extent of the injury to resident #009 while the home waited for the ordered assessment to be completed. When the results were received an injury was diagnosed and then treatment ensued.

Sources: Staff statements, identified critical incident report, interviews with PSWs #109, #110, RPN #111 and the Assistant Administrator. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance

required by the resident.

Inspector #672 conducted resident observations during two lunch meals, on identified resident home areas (RHAs). Due to the home experiencing a facility wide outbreak, all residents were isolated to their bedrooms and meals were served on disposable items, via tray service. The lunch meal service started at 1200 hours and the last resident was not assisted with their meal until more than one and a half hours after the beginning of the lunch service.

On a specified date, the lunch meal trays were served to nine residents at 1200 hours, and by 1330 hours, there were still five residents waiting for assistance with feeding. The food temperatures were checked by the Nutritional Services Manager (NSM) and found to be below acceptable levels.

On a specified date, the lunch meal trays were served to seven residents at 1205 hours, and by 1335 hours, there were still six residents waiting for assistance with feeding. Upon inspection, the styrofoam meal containers felt cool to the touch, and at 1337 hours, staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

During separate interviews, PSWs #107, #108, #113, Activity Aide #112. RPN #102 and RN #115 indicated it was a routine practice in the home for all trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. The staff members further indicated meals were served to residents without a staff member being available to provide the required assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the NSM and AA indicated the expectation in the home was meals to not be served to any resident who required assistance until a staff member was available to provide the required assistance. The NSM further indicated it was not an acceptable practice for a meal to not be served to a resident for more than an hour and a half after the initiation of the meal service, as this practice could have negative effects on the residents, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately. The NSM verified that staff were not following the expected practice in the home related to food service, when meals were served to residents prior to ensuring a staff member was available to provide the required

assistance. This failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of 1.5 hours.

Sources: Observations conducted, interviews with PSWs #107, #108, #113, Activity Aide #112. RPN #102, RN #115, the Nutritional Services Manager and the Assistant Administrator. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home the previous day. According to the CIR, both staff members and residents were affected with the illness.

According to the Assistant Administrator (AA), Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide.

Observations were conducted by the Inspector on specified dates and noted the following:

- There were six instances when the Personal Protective Equipment (PPE) stations had no garbage cans present for staff to doff used PPE.

- During every day of observation, no staff were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- During every day of observation, there were multiple instances of staff resting lunch trays on the clean PPE stations outside of resident rooms. Staff were also observed removing lunch trays from resident rooms without wearing gloves or completing hand hygiene after disposing of the trays.

- There were 22 instances when staff were observed and two instances when family members were observed donning/doffing PPE incorrectly.

- There were 14 instances when staff were observed entering resident's bedrooms and providing assistance without wearing the required PPE and completing hand hygiene afterwards.

- There was an instance of a staff member assisting a resident with an identified aerosolizing procedure without proper PPE in place to protect themselves. The staff member indicated they had not received training related to PPE donning and doffing or the equipment required when utilizing an aerosolizing procedure.

- RPN #106 was observed administering medications to residents without donning PPE or completing hand hygiene between every resident.

- RN #115 was observed wearing two surgical masks while exiting an ill resident's room. During an interview, RN #115 stated they were supposed to wear an N95 mask while assisting this resident due to them being actively symptomatic, with specified symptoms but did not have the required supplies.

- There were five instances of staff members wearing PPE incorrectly, such as double masking or gloving.

During an interview, the AA indicated they were aware there were challenges in the home with staff not adhering to the IPAC guidelines. The AA further indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance

was observed related to hand hygiene and PPE donning/doffing. As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the identified disease throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #101, #103, #104, #105, #107, #108, #113, #114, #117, RPNs #102 and #106, RN #115, Activity Aide #112 and the Assistant Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007's plan of care was provided to the resident as specified in the plan.

During resident observations related to infection prevention and control practices in the home, Inspector observed staff to resident interactions to ensure the required infection prevention and control procedures were being followed. During a resident observation, Inspector observed PSW #105 assisting resident #007 with an identified aerosolizing procedure while sitting in a lounge chair beside the bed.

During an interview, PSW #105 indicated they "always" assisted resident #007 with an identified aerosolizing procedure during a specified time, as it provided the resident with an identified effect.

During an interview, RPN #106 indicated resident #007 was only supposed to utilize the identified aerosolizing procedure at a different specified time, as it was a required therapy due to a specified diagnosis.

During record review, Inspector reviewed resident #007's current written plan of care, which stated resident #007 required the use of the identified aerosolizing procedure related to a specified diagnosis and staff were supposed to ensure the resident utilized the identified aerosolizing procedure at a specified time only.

During an interview, the AA indicated the expectation in the home was for staff to provide care to every resident as was specified in their plan of care. By not ensuring resident #007's plan of care was provided to the resident as specified in the plan, they were placed at risk of not having their needs met as required.

Sources: Resident #007's written plan of care; observation conducted; interviews with PSW #105, RPN #106 and the AA. [s. 6. (7)]

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 resident's plans of care are provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their medication administration policy included in the required medication program was complied with.

Ontario Regulation 79/10, s.114 (2), states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home.

Specifically, staff did not comply with the home's internal policy related to medication administration which directed that the nurse who prepared a medication or injection for administration, must administer it, not leave medications at bedside and not ask someone else to administer the medication.

During resident observations related to infection prevention and control practices in the home, Inspector observed part of a medication administration pass on an identified resident home area. During that observation, Inspector noted that RPN #102 was

administering medications by pouring the medications into a medication cup and leaving the cup with the medications on the resident's meal tray, for the residents to either take independently or to have the PSW staff administer the medications to the residents while they were assisting the resident with their food and fluid intake. RPN #102 was not observing the resident to ensure that all oral medications had been swallowed. Inspector observed PSW #108 entering resident #011's room with a meal tray and a plastic medication cup filled with medications and apple sauce. During an interview, the PSW indicated they were preparing to assist the resident with their meal, the RPN had provided the cup of medications and directed that they were safe for the PSW to administer to the resident while they were eating.

During an interview, RPN #102 verified they had provided several residents' medications on the meal trays for the PSW staff to assist with administering, or for independent residents to take on their own, without observing the intake of the medications. The RPN further indicated this practice decision was made due to feeling very overwhelmed at the time with the additional duties required related to the outbreak in the home, such as the extra time needed to don/doff PPE and having multiple residents who required physical assistance with their intake of the meal, but not enough staff to provide the required assistance.

During an interview, the Assistant Administrator indicated it was not an acceptable practice in the home for Registered staff to leave medications with residents or unregistered staff members and not observe and/or assist with the physical administration of the medications. The Assistant Administrator further indicated the home had the required amount of staff on the units to provide the required assistance. By not ensuring that residents were observed during administration of their medications, the were placed at risk of not receiving medications as prescribed and/or harm due to possible hoarding or inappropriate consumption of medications.

Sources: Observations conducted, internal policy related to medication administration and interviews with PSW #108, RPN #102 and the Assistant Administrator. [s. 8. (1) (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 that internal policies are complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately notified of the incident involving resident #009.

A Critical Incident Report was submitted to the Director related to an incident involving resident #009. According to the CIR, resident #009 was receiving a bath on the a specified date, when the resident began to exhibit identified responsive behaviours. Following the bath the resident was noted to have an injury and was complaining of pain. A specified assessment was completed on an identified date, which diagnosed resident #009 with an injury.

Review of the internal documents indicated the management team of the home became aware of the incident on an identified date, when the injury was diagnosed. The CIR indicated the Director was notified six days later.

During an interview, the Assistant Administrator indicated the management team had become aware of the incident after the injury was diagnosed. The Assistant Administrator further indicated the expectation in the home was for staff to immediately report any allegation of resident abuse and/or injury of unknown origin and the incident should have been immediately reported to the Director.

Sources: Staff statements, critical incident report and interviews with PSWs #109, #110, RPN #111 and the Assistant Administrator. [s. 24. (1)]

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 Director is immediately notified of any incident or allegation of resident abuse or neglect, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009's SDM was immediately notified upon becoming aware of the alleged incident of abuse that resulted in a physical injury or pain to the resident.

A Critical Incident Report was submitted to the Director related to an incident involving resident #009. According to the CIR, resident #009 was receiving a bath on the a specified date, when the resident began to exhibit identified responsive behaviours. Following the bath the resident was noted to have an injury and was complaining of pain. A specified assessment was completed on an identified date, which diagnosed resident #009 with an injury.

Review of the progress notes indicated that resident #009's SDM was not notified of the incident or the injury until the injury was diagnosed six days later.

During an interview, RPN #111 indicated they were the nurse on duty when the incident with resident #009 occurred. RPN #111 further indicated they had not notified resident #009's SDM of the incident or the resident's injury that day.

During an interview, the Assistant Administrator indicated the expectation in the home was for staff to immediately report any allegation of resident abuse to their SDM. The Assistant Administrator further indicated the staff had not reported the incident to the SDM that day as they were unsure of what had happened to cause the injury and were not sure if it was an incident of abuse or not, but they should have reported that the resident had sustained an injury.

Sources: Resident #009's progress notes, physician's orders, identified assessment results and interviews with RPN #111 and the Assistant Administrator. [s. 97. (1) (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 residen's SDMs are immediately notified upon becoming aware of any alleged incident of abuse that results in a physical injury or pain to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure the Director was notified immediately of an outbreak of a disease of public health significance occurring in the home.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home with both staff members and residents affected with the illness. According to the AA, Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide.

Inspector reviewed the Critical Incident Report and noted it had been submitted to the Director more than 24 hours after Public Health declared the entire home in a confirmed outbreak, and did not note any documentation which indicated the Director had been notified prior to the submission of the CIR.

During an interview, the AA indicated they had not informed the Director of the outbreak occurring in the home prior to the submission of the CIR. The AA further indicated they were not aware of the legislative requirement to notify the Director immediately of an outbreak and believed they had one day to inform the Director, therefore had submitted the CIR the following day.

Sources: Critical Incident Report and interview with the AA. [s. 107. (1) 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 o ensure the Director is notified immediately of an outbreak of a disease of public health significance occurring in the home, to be implemented voluntarily.

Issued on this 11th day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l’inspection :	2021_715672_0003
Log No. / No de registre :	023716-20, 000403-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 10, 2021
Licensee / Titulaire de permis :	Mon Sheong Foundation 36 D'Arcy Street, Toronto, ON, M5T-1J7
LTC Home / Foyer de SLD :	Mon Sheong Richmond Hill Long Term Care Centre 11199 Yonge Street, Richmond Hill, ON, L4S-1L2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sherry Li

To Mon Sheong Foundation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with section s. 19 (1) of the LTCHA.

Specifically, the licensee must:

1. Ensure that residents are not neglected by the licensee and staff. The details of the finding must be reviewed with direct care staff assigned to resident #009's care.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #009 was free from abuse by the staff in the home.

For the purposes of the Act and Regulation, "Neglect" is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an incident involving resident #009. According to the CIR, resident #009 was receiving a bath on the a specified date, when the resident began to exhibit identified responsive behaviours. Following the bath the resident was noted to have an injury and was complaining of pain. A specified assessment was completed on an identified date, which diagnosed resident #009 with an injury.

Record review indicated that resident #009 had responsive behaviours, with

interventions listed for staff members to implement as required. Progress notes indicated the physician had been notified on on a specified date, of the observed injury and they ordered a specified assessment. Between an identified period of time, the resident had documented complaints of pain, exhibited non-verbal signs of pain and was guarding the injured body part which had visible injuries noted. There was no follow up regarding when the specified assessment would be completed between an identified period of time, nor was the physician notified of the delay in having the test completed, resident #009's visible injuries or ongoing complaints of pain.

During separate interviews, PSWs #109 and #110 indicated they were bathing the resident when the resident began to exhibit identified responsive behaviours. PSWs #109 and #110 further indicated they continued to provide care to the resident after the resident began to exhibit identified responsive behaviours and were unaware of how the injury to the resident occurred.

During an interview, RPN #111 indicated they had not followed up and were not aware of any other staff member following up regarding when the specified assessment would be completed between an identified period of time. RPN #111 also did not believe the physician had been notified of the delay in having the assessment completed and had not considered transferring resident #009 to the hospital for further assessment due to concerns related to the pandemic.

During an interview, the Assistant Administrator indicated the expectation in the home was for staff to follow up with the provider and notify the physician if an ordered test had not been completed within the expected 24 to 48 hours. The Assistant Administrator further indicated they were unaware of how the injuries to resident #009 had occurred, as they had not interviewed staff members following the incident, they had only requested staff statements. The staff statements indicated staff were unaware of how the injuries occurred.

By not ensuring that staff followed up on resident #009's injury within the expected 24 to 48 hours, there was no follow up for an identified period of time to determine the extent of the injury to resident #009 while the home waited for the ordered assessment to be completed. When the results were received an injury was diagnosed and then treatment ensued.

Sources: Staff statements, identified critical incident report, interviews with PSWs #109, #110, RPN #111 and the Assistant Administrator.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #009 as they were left for an identified period of time with an undiagnosed injury which did not receive treatment during that time, which led to pain and exhibited responsive behaviors.

Scope: The scope of this non-compliance was isolated, as one resident was affected.

Compliance History: The licensee had received two previous Voluntary Plans of Correction (VPCs) within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 10, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with section s. 73. (2) (b) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure the residents who require assistance with eating or drinking will not be served a meal until someone is available to provide the required assistance.

Grounds / Motifs :

1. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Inspector #672 conducted resident observations during two lunch meals, on identified resident home areas (RHAs). Due to the home experiencing a facility wide outbreak, all residents were isolated to their bedrooms and meals were served on disposable items, via tray service. The lunch meal service started at 1200 hours and the last resident was not assisted with their meal until more than one and a half hours after the beginning of the lunch service.

On a specified date, the lunch meal trays were served to nine residents at 1200 hours, and by 1330 hours, there were still five residents waiting for assistance with feeding. The food temperatures were checked by the Nutritional Services Manager (NSM) and found to be below acceptable levels.

On a specified date, the lunch meal trays were served to seven residents at 1205 hours, and by 1335 hours, there were still six residents waiting for assistance with feeding. Upon inspection, the styrofoam meal containers felt cool to the touch, and at 1337 hours, staff were noted to begin assisting two residents with their meals but did not offer to reheat the food items.

During separate interviews, PSWs #107, #108, #113, Activity Aide #112. RPN #102 and RN #115 indicated it was a routine practice in the home for all trays to be delivered to the resident bedrooms immediately upon being plated, and then a staff member would enter the room to assist the resident with their intake once they became available. The staff members further indicated meals were served to residents without a staff member being available to provide the required assistance due to the home not having the required amount of staff members present to perform all of the duties required in a timely manner during the outbreak.

During separate interviews, the NSM and AA indicated the expectation in the home was meals to not be served to any resident who required assistance until a staff member was available to provide the required assistance. The NSM further indicated it was not an acceptable practice for a meal to not be served to a resident for more than an hour and a half after the initiation of the meal service, as this practice could have negative effects on the residents, such as decreased intake due to improper temperatures of the food and/or meals not being spaced out appropriately. The NSM verified that staff were not following the expected practice in the home related to food service, when meals were served to residents prior to ensuring a staff member was available to provide the required assistance. This failure to provide assistance to residents who needed to be fed their meals posed a risk of poor intake, decreased enjoyment of the meal and contamination of the food or fluid items, as meals were left sitting in excess of 1.5 hours.

Sources: Observations conducted, interviews with PSWs #107, #108, #113, Activity Aide #112. RPN #102, RN #115, the Nutritional Services Manager and the Assistant Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as residents were served meals more than an hour prior to receiving the required assistance for food and fluid intake. This practice could lead to food contamination and decreased intake due to unpalatable temperatures.

Scope: The scope of this non-compliance was widespread, as more than four residents were affected.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 20, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A Critical Incident Report was submitted to the Director related to an outbreak declared in the home the previous day. According to the CIR, both staff members and residents were affected with the illness.

According to the Assistant Administrator (AA), Public Health declared the entire home in a confirmed outbreak and staff were directed to follow contact and droplet precautions home wide.

Observations were conducted by the Inspector on specified dates and noted the following:

- There were six instances when the Personal Protective Equipment (PPE)

stations had no garbage cans present for staff to doff used PPE.

- During every day of observation, no staff were observed to wipe/disinfect their face shields/eye protection upon exiting resident rooms and acknowledged the expectation in the home was to clean the face shields/eye protection from inside to outside upon exiting resident's rooms.

- During every day of observation, there were multiple instances of staff resting lunch trays on the clean PPE stations outside of resident rooms. Staff were also observed removing lunch trays from resident rooms without wearing gloves or completing hand hygiene after disposing of the trays.

- There were 22 instances when staff were observed and two instances when family members were observed donning/doffing PPE incorrectly.

- There were 14 instances when staff were observed entering resident's bedrooms and providing assistance without wearing the required PPE and completing hand hygiene afterwards.

- There was an instance of a staff member assisting a resident with an identified aerosolizing procedure without proper PPE in place to protect themselves. The staff member indicated they had not received training related to PPE donning and doffing or the equipment required when utilizing an aerosolizing procedure.

- RPN #106 was observed administering medications to residents without donning PPE or completing hand hygiene between every resident.

- RN #115 was observed wearing two surgical masks while exiting an ill resident's room. During an interview, RN #115 stated they were supposed to wear an N95 mask while assisting this resident due to them being actively symptomatic, with specified symptoms but did not have the required supplies.

- There were five instances of staff members wearing PPE incorrectly, such as double masking or gloving.

During an interview, the AA indicated they were aware there were challenges in the home with staff not adhering to the IPAC guidelines. The AA further

indicated they were in the process of providing education and training to the staff related to the proper usage of PPE supplies and completing on the spot redirection when incidents of noncompliance was observed related to hand hygiene and PPE donning/doffing. As there was an outbreak at the home, the observations and interviews demonstrated that there were inconsistent IPAC practices from the staff of the home. These inconsistent practices posed an actual risk of harm to the residents due to the rapid spread of the identified disease throughout the home. The risk associated with the staff not adhering to the home's IPAC program would be probable transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs #101, #103, #104, #105, #107, #108, #113, #114, #117, RPNs #102 and #106, RN #115, Activity Aide #112 and the Assistant Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because the home was in an outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months.

(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 20, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office