Ontario

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

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

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

Original Public Report

Report Issue Date: August 17, 2023	
Inspection Number: 2023-1428-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Scarborough Long Term Care Centre, Scarborough	
Lead Inspector Rexel Cacayurin (741749)	**Inspector Digital Signature** Rexel J Cacayurin Digitally signed by Rexel J Cacayurin Date: 2023.09.05 11:16:11 -04'00'
Additional Inspector(s) Jennifer Brown (647) Reethamol Sebastian (741747)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21, 24-26, 2023

The following intake(s) were inspected:

- An intake complaint related to the allegation of staff to resident abuse.
- An intake related to the allegation of staff to resident neglect.
- An intake related to responsive behavior.
- An intake related to improper care of a resident.
- An intake related to the allegation of a staff to resident abuse.

The following intakes were completed in this inspection:

- Intakes related to falls.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviors
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dining and snacks service

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 73 (1) 10.

The licensee has failed to ensure the use of proper techniques and safe positioning to assist a resident with eating.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a complaint from the resident's family regarding improper positioning of the resident while eating.

The complaint note documented that during dinner the family member found the resident laying in bed improperly positioned for eating and drinking.

The home's investigation notes documented Personal Support Worker (PSW) set the table over a resident's lap while they were sitting upright in bed at the time. The resident began eating and staff then left to deliver trays to other residents. Further, the Director of Resident Care (DORC) acknowledged in the complaint response letter to the family, that there was a potential risk to the resident due to PSW's decision to leave the resident alone.

The resident's care plan and the RD confirmed they required supervision at all times during snacks and meals due to their health condition.

PSW indicated that the resident was found by the family member in an improper eating position in bed. The PSW mentioned that the expectation of the home was to properly position the resident at 90 degrees upright seated position to minimize the risk of choking and aspiration.

The RD, DORC, and registered staff acknowledged in separate interviews that the home's expectation was to position the resident in an upright sitting position if tolerated to prevent choking and aspiration while eating and drinking.

Failing to ensure staff used proper techniques to feed the resident put them at risk of choking and aspiration.

Sources: CIR, interviews with PSW, RD, DORC, and registered staff, complainant note, internal investigation documents, and resident's care plan.

[741749]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

The licensee failed to ensure resident's right to have their lifestyle and choices, in relation to personal care was fully respected.

Rationale and Summary

A complaint and CIR were submitted to the Director related to alleged abuse and care concerns towards a resident by a PSW. The complaint was related to personal care resulting in injury by PSW toward the resident.

The home's internal investigation notes documented that PSW did not respect the resident's right to participate in decision-making in relation to personal care. The resident requested the PSW to stop providing the care. However, the PSW ignored the request and continued to provide care without consent which resulted in an injury to the resident.

In an interview, PSW denied the above-mentioned allegation. However, the DORC confirmed that PSW did not treat the resident with dignity and respect when providing care. The PSW was disciplined as a result of the incident.

Failure to ensure the resident was treated in a manner that respected their lifestyle and choices posed a moderate risk to the resident's well-being.

Sources: CIR, the home's internal investigation notes, resident's clinical records, the Home's policy titled, "Abuse Policy", last updated on July 2022, staff disciplinary action record, and interviews with PSW and DORC.

[741747]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with by PSW, specific to the alleged abuse of a resident.

Rationale and Summary

A complaint and CIR were submitted to the Director related to alleged abuse and care concerns towards a resident by a PSW. The complaint was related to the delay in transfer assistance.

The home's internal investigation notes indicated that the resident's family requested twice for the PSW to transfer the resident from the assistive device to the bed. However, the PSW delayed the transfer of the resident by approximately half an hour.

In an interview, PSW denied the above-mentioned allegation. However, the DORC confirmed through investigation, that abuse incident, neglect, violation of the abuse policy, and resident's bill of rights were found. As a result, the staff was disciplined. The DORC indicated the PSW should have requested another staff for help and should not have delayed the resident's transfer. The DORC confirmed that the resident was in the assistive device for longer than they were able to tolerate.

Failure to ensure staff followed the policy to promote zero tolerance of abuse and neglect impacted the resident's quality of life and their care.

Sources: CIR, the home's internal investigation notes, resident's clinical records, the Home's policy titled, "Abuse Policy", last updated on July 2022, staff disciplinary action record, and interviews with PSW and DORC.

[741747]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC standard 9.1 (f)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The IPAC Lead or designate will provide education to PSW, registered staff, and other staff regarding the required additional Personal Protective Equipment (PPE) including proper donning and doffing during the COVID-19 outbreak and Respiratory outbreak. Keep a documented record of who provided the education, the date of the education provided, the names of the staff who received the education, and the contents of the education.

2. The IPAC Lead or designate is to conduct daily audits on day and evening shifts of specific resident home areas for proper use in resident rooms and areas where additional precautions are required for a minimum of two weeks.

Grounds

Non-compliance with O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (f).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to ensure that additional precaution shall include additional PPE requirements including appropriate selection, application, removal and disposal were followed as is required by Additional Requirement 9.1 (f) under the IPAC Standard for Long Term Care Homes, April 2022.

Rationale and Summary

During the inspection, the home was on outbreak declared by Toronto Public Health in two resident home areas.

Additional precautions signage was posted on the door of a resident room which indicated staff must use fitted N95 mask. A PSW was observed inside the room not wearing N95 mask while providing direct care to the isolated resident. The PSW stated that they had forgotten to wear N95 mask and were aware to use of the required PPE. Further, they indicated that the resident was in isolation due to a confirmed test result.

Registered staff was observed wearing only a surgical mask without a face shield in the outbreak unit. Signages were posted on the unit entrance door which indicated face shield and fitted N95 mask were mandatory for staff and visitors. In addition, staff was observed feeding a resident in the dining area of the same unit wearing only a surgical mask. The registered staff indicated the expectation was to wear a fitted N95 mask and face shield before entering the unit.

The DORC and Assistant Director of Resident Care (ADORC) acknowledged that staff were expected to follow signages posted and were required to wear N95 mask and face shield in an outbreak unit and before entering an additional precaution room.

Failure to ensure PPE requirements were followed by staff could lead to transmission of infection.

Sources: Observation, interviews with PSW, Registered staff, DORC, and ADORC, Public health communication document.

[741749]

This order must be complied with by September 15, 2023.

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.