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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2021	2021_869120_0001	016740-21	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 Stouffville Long-Term Care Centre
162 Sandiford Drive Stouffville ON L4A 0V6

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

BERNADETTE SUSNIK (120), JACK SHI (760)

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): November 5, 8, 9, 2021

During the course of the inspection, the inspector(s) reviewed records, conducted interviews, observations and measured hot water temperatures.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Director of Resident Care, (DORC) Administrator, Assistant Administrator, Home Area Assistant (HAA), housekeeping/laundry manager, maintenance staff, and dietary staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
1 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 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 failed to ensure that a resident was protected from emotional abuse by PSW #108.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident”.

A Critical Incident Systems (CIS) report was submitted by the home regarding an allegation of resident abuse between a resident and a PSW. According to the home’s investigation, the resident approached a Home Area Assistant (HAA) and PSW #109 and told them that PSW #108 had emotionally abused them. The resident expressed they were afraid to call for assistance after the incident. The DORC stated that based on the resident’s statement of what occurred and their reaction to the situation, they had believed the resident was emotionally abused by the PSW. The DORC stated that as a result of their investigation and this incident, this PSW was removed from working in the home.

Sources: Home’s investigation; Interviews with DORC and other staff. [s. 19. (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 a resident #001 is protected from emotional abuse by a PSW #108, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where resident bed systems included bed rails, that they were evaluated in accordance with evidence-based practices to minimize risk to the resident.

Evidence-based practices related to bed evaluations identifies the importance of measuring entrapment gaps in and around every bed rail when attached or re-attached to the bed frame. Three residents were admitted to the home over the course of the last 4 weeks, assessed by an RPN for their clinical need for a bed rail and all three received a bed rail. Although the beds were new and a representative from the bed manufacturer measured the bed rails for entrapment gaps after the beds were delivered to the home, the bed rails were all removed after this process. None of the bed rails were re-evaluated for entrapment gaps after they were re-installed. No documentation could be presented for review as to the date the entrapment gaps were measured, by whom, the status of the evaluation and which registered staff member was informed.

The licensee's procedure RC-5.2 (Entrapment Safety) included the need for the DORC or designate to co-ordinate an entrapment test with the "service provider" and "volunteer services" at an annual basis and as needed. No guidance was included as to circumstances that would require an entrapment test "as needed". The service provider nor the volunteer service position was clarified as to their role, tasks, equipment needed or qualifications for conducting an entrapment test. The maintenance department's role and how registered staff are informed about the status of the bed rail entrapment status was also missing from the procedure.

RPN #104 who conducted two resident bed rail assessments, notified a maintenance person to install bed rails and was not informed whether the bed rails passed entrapment or not. A maintenance person confirmed that they had installed bed rails on three different beds without conducting an entrapment test.

There was a potential risk for residents to become entrapped where bed rails were not evaluated for entrapment gaps prior to use in accordance with evidence-based practices.

Source: Staff interviews, policy/procedure R.C- 5.2, Health Canada - Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008. [s. 15. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system clearly indicated when activated, where the signal was coming from.

The licensee's resident-staff communication and response system was designed to include the use of a portable phone to alert staff as to when and where an activation station (nurse call bell) has been activated by a resident, staff or visitor. They are to be carried by staff at all times while working their shift. The portable phones have both an audio and visual component.

PSWs #112, #115 and #116 did not have their portable phones on their person when they were requested to produce them by the inspectors during the last day of the inspection. Inspector's also observed four portable phones inserted into their chargers at one of the home area nursing stations which were only distributed to PSWs by an RPN during the inspection.

There was potential risk to residents as the staff did not have a method in which to determine which residents were requesting assistance and when.

Source: Staff interviews and observations. [s. 17. (1) (f)]

WN #4: 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 failed to ensure that an allegation of staff to resident abuse was reported to the Director immediately.

A CIS report was submitted by the home regarding an allegation of resident emotional abuse between a resident and a PSW. According to the home’s investigation, the resident had reported the allegations to a Home Area Assistant (HAA) and a PSW on the morning of specified date in October 2021. The DORC stated they were informed of this incident on the same date in October 2021 but did not report the allegation to the Director until the following day. The DORC acknowledged that any allegations of resident emotional abuse should have been reported to the Director immediately and this incident was reported late to the Director.

Sources: Home’s investigation report; Interviews with the DORC and other staff. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that a PSW utilized appropriate strategies to communicate with a resident.

A CIS report was submitted by the home regarding an allegation of resident emotional abuse between the resident and the PSW. According to the investigation report, the PSW mentioned that the resident had used their communication device continuously during their shift for no apparent reason. The investigation report concluded that one of the possible factors that contributed to the incident was the language barrier between the PSW and the resident. An RPN Supervisor stated that if the resident was continuously using their communication device for no reason and their needs were not being met, the PSW should have called for the charge nurse to assist in translating and finding out what the needs of the resident were. The DORC added that this PSW did not utilize the proper techniques to communicate with this resident’s needs.

Sources: Home’s investigation report; Interview with RPN Supervisor, DORC and other staff. [s. 43.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of resident care equipment, such as tubs, shower chairs and lift chairs in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee had tubs, shower chairs and lift chairs requiring cleaning and disinfection after each resident use. The method and specific tasks to clean and disinfect each item type was not developed. Procedures posted in multiple tub and shower rooms required staff to spray a disinfectant thoroughly to the tub (or shower), use a brush to remove dirt and debris, allow the product to sit for 5-10 minutes, followed by thorough rinsing. Written procedures developed for tub and shower chairs were not specific and required staff to "clean and disinfect" them without any other details. Tub lift chairs were not included in any cleaning and disinfecting procedures.

Procedure NPS 4.2.6 on bathing and showering did not include which disinfectant to use (specific name of product), how the disinfectant product would be applied as per manufacturer's directions (by course trigger spray), how the product would be diluted if using a concentrated product (the disinfectant product was undiluted when observed stored in shower and tub rooms), which type of trigger spray is to be used and how much to apply when "sprayed" on the different types of surfaces.

The tub systems in the home were purchased and installed without an automatic disinfectant dispensing system built into the tub. Prior to receiving an occupancy licence, the licensee was advised to install an external disinfection dispensing system for ease of use and proper application of the disinfectant product in order to eliminate the use of small spray bottles. However, the dispensing system that was installed did not have a method in which to apply the disinfectant in the form of "coarse trigger spray" (by using a hand controlled shower wand or similar). Other methods were therefore made available to staff, including the use of small spray bottles and pressurized foaming spray bottles to apply a low level disinfectant. When PSWs #101, #110 and #111 were interviewed as to how they cleaned and disinfected the tubs and shower chairs, each had a different method of application. Two used the foam sprayer and one a regular spray bottle. PSW #111 used a disposable disinfectant wipe for the shower chair.

During a tour of three different tub and shower rooms, two tub rooms included pressurized sprayers that were missing a label. The sprayer in third tub room had an unknown liquid inside (clear instead of yellow which was the colour of the disinfectant product). Neither the RPN or PSW that used the product knew what the product was.

Sources: Staff interview, observation, record review (Bathing - NPS 4.2.6) [s. 87. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that immediate action was taken when the water temperature exceeded 49 degrees Celsius.

Hot water temperature logs were requested for review for the month of October 2021 (residents were first admitted beginning Oct. 4, 2021). The logs however did not have the month that the temperatures were taken identified on them. It appeared that during the month of October 2021, temperatures between 49.2 to 50.8 degrees Celsius were recorded frequently on two specific floors. Another floor also had hot water temperatures over 49 degrees Celsius on four separate days, two of which had a response documented as "reported".

The licensee's "Hot Water Temperature" procedure RC-5.16 requires that staff measuring and recording the temperature immediately report the exceedance to the charge nurse and Support Services Supervisor, who in turn would implement certain interventions. The "Hot Water Temperature Check" form provided for review did not include any information related to what action was taken under the "comments" section for the exceedances on the two specific floors.

RPNs #104, #113 and #114 reported that some of the exceedances were documented in the maintenance log and that maintenance staff entered their initials to acknowledge that they saw the entry. RPNs were not aware of the exceedances during the month of October 2021.

During the inspection, hot water temperatures were measured on two separate resident accessible floors with a digital probe thermometer. The temperatures were 50.1 and 50 degrees Celsius.

There was a potential risk of scalding to residents due to staff not implementing their hot water monitoring procedures.

Source: Staff interviews, temperature records, hot water measurements, water temperature procedure RC-5.16 [s. 90. (2) (h)]

2. The licensee failed to ensure that procedures were implemented to monitor the water temperature once per shift in random locations where residents had access to hot water where a computerized system to monitor the hot water was not in use.

The licensee does not have a computerized water monitoring system, and HAAs were therefore tasked at measuring and recording the temperatures. However, the records indicated that the temperatures were only documented once per day. The licensee's procedure AS-11.7 requires the hot water temperature to be monitored once per shift.

Source: Staff interviews, temperature records, water temperature procedure AS - 11.7 [s. 90. (2) (k)]

Issued on this 25th day of November, 2021

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

Original report signed by the inspector.