Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 25, 2015	2015_235507_0023	030274-15	Resident Quality Inspection

Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street TORONTO ON M5T 1J7

Long-Term Care Home/Foyer de soins de longue durée

MON SHEONG SCARBOROUGH LONG TERM CARE CENTRE
2030 Mcnicoll Avenue SCARBOROUGH ON M1V 5P4

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

STELLA NG (507), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 4, 5, 6, 9, 10, 12, 13 and 16, 2015.

The following Complaint Intake was inspected concurrently with this Resident Quality Inspection: 003434-15.

During the course of the inspection, the inspector(s) spoke with the Senior Administrator (SA), Assistant Director of Resident Care (ADORC), Food Service Manager (FSM), Dietary Aide (DA), Registered Dietitians (RDs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Student Nurse, Personal Support Workers (PSWs), Activation Supervisor (AS), Activity Aide (AA), Social Services Coordinator (SSC), Physiotherapy Assistants (PAs), Assistant Accountant, Accounting Supervisor, Housekeeping Aide, residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment on an identified date of resident #006 revealed the resident's vision was assessed by nursing staff as moderately impaired, and not able to read newspaper headlines. The resident did not use any visual appliances or corrective lenses. On the same day, the resident was assessed by the activation staff revealed reading was one of the resident's preferred activity based on the resident's abilities.

Interview with the resident revealed he/she was not able to read in the past months due to deteriorated vision. Interview with staff #116 revealed he/she has not seen the resident read.

Interview with staff #100 confirmed that staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident in regards to the resident's vision so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On an identified date, during afternoon (PM) snack service, the inspector observed resident #001 was served a nutritional supplement of nectar consistency. On two identified dates, at an identified time, the inspector observed resident #001 was not served a specified beverage as indicated in the resident's plan of care.

Review of the resident's care plan revealed resident #001 had nutritional, chewing and swallowing problems. The plan of care directs staff to provide a specified therapeutic diet, specified texture and fluid consistency at meals and snacks, and 120 millilitres (ml) of a specified beverage at an identified time due to health condition.

Interview with staff #131 indicated the supplement was not thickened to the specified consistency and he/she did not prepare the snack to the specified consistency for the resident on the above mentioned identified date. The inspector brought the snack to staff #129's attention. After assessing the consistency, staff #129 confirmed the snack prepared by staff #131 was not the required specified consistency snack for resident #001.

Interview with staff #122 confirmed the resident did not receive the specified beverage during the identified time on the above identified dates.

Interview with staff #131 confirmed resident #001 required the specified beverage daily at the identified time due to health condition. [s. 6. (7)]

3. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Record review of the RAI-MDS quarterly assessment on an identified date revealed resident #003 required supervision by one staff for toileting and required assistive device for mobility. The RAI-MDS annual assessment dated three months later revealed that

extensive assistance by two staff was required for toileting and a different type of mobility aid other than assistive device for mobility. The care plan of an identified date indicated under the toileting focus that resident #003 required supervision in toileting, the mobility focus related to walking in corridor and walking in room indicated that resident #003 required supervision and was able to walk in the corridor and his/her room with assistive device.

Interviews with staff #135 and #126 revealed that resident #003 could no longer toilet him/herself and required extensive assistance by two staff to stand and pivot for toileting. They further revealed that a different type of mobility aid other than assistive device for mobility.

Interview with staff #114 confirmed that resident #003's care plan had not been revised to indicate that the resident's care needs had changed. [s. 6. (10) (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:
1. the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
2. the care set out in the plan of care is provided to the resident as specified in the plan, and
3.resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing is provided to the Family Council within 10 days of receiving the Family Council advice related to concerns or recommendations.

Record review of the Family Council's meeting minutes for an identified month indicated concerns and suggestions were made during the meeting three months prior regarding different aspects of resident's care including improper vital signs measurement techniques, transfer and personal equipment not being sanitized after use or between resident, delay in call bell responses, rushed shower, home's palliative care program among other.

Review of the Suggestions/Requests, Concerns and Complaints Form revealed staff #118 responded to the above mentioned concerns and suggestions three months after receiving the concerns/ suggestions.

Interview with the staff #118 confirmed he/she received the above mentioned concerns and suggestions on an identified date, and he/she responded to the Family Council by email two months after receiving the concerns/suggestions from the Family Council. [s. 60. (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 a response in writing is provided to the Family Council within 10 days of receiving the Family Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods in the food production system are prepared using methods to preserve taste, nutritive value, appearance and food quality.

On an identified date, during PM snack service, the inspector observed residents on pureed diet and thickened fluids being offered liquefied cookie and egg sandwich soaked in water.

Interview with staff #131 indicated he/she mixed one cookie with one quarter cup of water to produce a pureed consistency. The staff also indicated he/she soaked an egg salad sandwich in water to soften it for pureed texture diet.

Review of the method to produce pureed cookie described on the package directs staff to crush biscuit with beverage to a creamy consistency.

Review of white bread pureed standardized recipe revealed the following ingredients are needed to produce 85 portions of pureed bread: 44 sliced soft white bread, two ounces (oz) granulated white sugar, two fluid (FL) oz sweetener, eight FL-oz margarine, one FL-oz vanilla extract flavour, eight litres (L) 2% milk. The recipe directs staff to soak bread with eight L of milk and use the food processor to puree bread with the remaining ingredients.

Interview with staff #129 indicated some ingredients were missing when soaking bread in water when preparing a pureed snack sandwich. In addition, this was not prepared according to the method described in the standardized recipe. He/she stated the pureed cookie was liquefied. The FSM confirmed the above pureed food should not have been offered to residents on pureed texture and thickened fluid consistency diet because of improper consistency. [s. 72. (3) (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 all foods in the food production system are prepared using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) On an identified date, the inspector observed torn empty medication pouches thrown into the garbage bag attached to the medication carts on two identified home areas.

Interviews with staff #121 and #122 revealed that since the pharmacy changed the packaging a few months ago they were not able to dissolve resident names in water, and it became their practice to completely tear the name off the medication pouches and throw into clear garbage bag attached to the medication carts. Interview with staff #132 who has been employed by the home six months prior, revealed he/she has been disposing of medication pouches in the manner as previously described.

Interview with staff #133 revealed that when he/she emptied the garbage bags from the medication carts, the garbage bags are placed into a larger black garbage bag and then into a grey garbage bin located in the soiled utility room. He/she was unaware of where the garbage in the grey bin was disposed of.

Interview with staff #114 revealed that the grey garbage bin was disposed as regular garbage, and it is the home's expectation that the registered staffs are to place opened medication pouches into white paper bags and then dispose of them in the shredder to protect resident personal health information (PHI). Staff #114 confirmed that the registered staffs are not meeting the home's expectations in keeping resident's PHI confidential as per the Act.

b) On an identified date, the inspector observed a medication cart left unattended in the hallway near an identified resident room, with the medication administration record (MAR) binder open to resident #028's MAR. The inspector also observed a visitor passing by the medication cart.

Staff #134 was observed by the inspector to be in resident #028's room and did not have the medication cart within his/her eyesight.

Interviews with staff #134 revealed that when a medication cart is left unattended the MAR binder is to be closed.

Interview with staff #114 confirmed that the MAR binder is to be closed when a medication cart is left unattended to ensure resident PHI is kept confidential as per the Act. [s. 3. (1) 11. iv.]

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 failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

The home's policy titled "Skin and Wound Care Program", reference #RC-4.10, dated July 2015, indicated that stage II pressure ulcers are to be referred to the registered dietitian (RD) for nutritional assessment. The policy also indicated that skin/wound care committee, dietitian and physiotherapist/ occupational therapist will be consulted for stage I, III and IV as needed.

Interview with staff #114 who defined "as needed" when the registered staff have a situation that they cannot handle, for example a resident with reddened heels that do not improve after skin and wound care protocols have been initiated.

The above mentioned policy reveals stage II pressure ulcers are to be referred to RD, and RD will be consulted as needed for stage I, III and IV pressure ulcers.

This policy is not in accordance with the regulation that states the RD is to make an assessment of any resident with "altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds" and does not refer to any specific staging of skin breakdown.

Interview with staff #114 confirmed that the above mentioned policy is not in accordance with all applicable requirements under the Act. [s. 8. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date, the inspector observed an unlocked medication cart left unattended in the hallway near an identified resident room.

The inspector observed staff #112 seated at the nursing station and did not have the medication cart within his/her eyesight, staff #134 was in resident #028's room and did not have the medication cart within his/her eyesight. The inspector also observed a visitor passing by the unattended medication cart.

Interviews with staff #112 and #134 revealed that when a medication cart is left unattended it is to be kept locked for resident safety.

Interview with staff #114 confirmed that medication carts are to be secure and locked at all times when left unattended. [s. 129. (1) (a)]

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.