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
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 7, 2024
Inspection Number: 2023-1636-0006
Inspection Type: Complaint Critical Incident Follow up
Licensee: Mon Sheong Foundation
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville

Lead Inspector	**Inspector Digital Signature**
Miko Hawken (724)	Miko Hawken Digitally signed by Miko Hawken Date: 2024.02.27 14:10:25 -05'00'

Additional Inspector(s)
Deborah Nazareth (741745)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2-5, 8, 10-12, 15 & 16, 2024
The inspection occurred offsite on the following date(s): January 9, 2024

The following intake(s) were inspected:

- An intake: related to falls
- Two intakes related to COVID-19 outbreaks
- An intake for a First Follow-up - Compliance Order (CO) #001 from Inspection #2023-1636-0005, O. Reg 246/22, s. 102 (2) (b), Compliance Due Date (CDD): November 17, 2023

- An intake related to concerns of plan of care, assessment, policies, meals, hypoglycemia

The following intakes were completed in this inspection: Four intakes related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1636-0005 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Miko Hawken (724)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure - licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director a written complaint that alleged risk of harm concerning the care of a resident by a Registered Practical Nurse (RPN).

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a complaint regarding the care of a resident. The complaint alleged a risk of harm to the resident from a nurse who was not following the plan of care. Also, the complainant was unsure if the Long-Term Care Home (LTCH) had forwarded their concern to the Director.

The LTCH received a written complaint through electronic mail. The complaint was related to the care a resident had received from an RPN. The complaint alleged that the RPN was not following the plan of care for the resident concerning specific tasks. The complaint stated that failing to follow instructions caused risk of harm to the resident.

The Acting Assistant Director of Resident Care (ADORC) and the Acting Director of Resident Care (DORC) acknowledged that a complaint regarding the care of the resident was received in writing and alleged risk of harm to the resident. Further the complaint should have been forwarded to the Director.

Failing to immediately inform the Director of this complaint posed no risk to the resident.

Sources: LTCH Complaints Binder, LTCH policy Complaint Procedures, interviews with staff. [741745]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

The LTCH submitted a Critical Incident Report (CIR) regarding the fall of a resident. The resident fell and sustained an injury. The next day the resident passed away. The resident's plan of care required two staff to transfer them using specified

equipment. The PSW transferred the resident on their own. The resident passed away shortly after.

The PSW stated that they were unaware of the resident's transfer status. The PSW acknowledged they should have consulted the resident's care plan before they transferred them on their own. The ADORC confirmed the PSW did not follow the plan of care for the resident.

The resident was at risk for injury when the PSW transferred them on their own without using specified equipment.

Sources: Resident's clinical record, Critical Incident Report, LTCH's investigation notes, interviews with staff. [741745]

WRITTEN NOTIFICATION: Hazardous Substances

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure that all hazardous substances at the home were labelled properly.

Rationale and Summary

During an interview with a housekeeper it was observed that a bottle of cleaner on the housekeeping cart, identified as peroxide cleaner, was not properly labelled

with a manufacturers label.

The safety data sheet for the peroxide cleaner outlined the product was corrosive and that it may cause an allergic skin reaction and eye irritation when reconstituted.

Housekeeper and the housekeeping supervisor confirmed that the peroxide cleaner was a hazardous substance and that it required decanting and reconstitution and thus required a manufacture's label.

Failing to ensure that the hazardous substance was labelled correctly posed a safety risk to housekeeping staff and residents, and also for identification of the correct product to use on the correct surfaces.

Sources: Observation, Safety Data, interviews with staff. [724]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the Infection Prevention and Control (IPAC) program in accordance with the Standard for Long-Term Care Homes (LTCH) issued by the Director, revised September 2023.

Rationale and Summary

In accordance with the IPAC Standards for LTCHs, section 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include, F) Additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Specifically, the licensee did not ensure that Personal Support Worker (PSW) applied the appropriate PPE, while providing care for a resident, who was on additional precautions.

A PSW was observed in a resident room while assisting the resident to eat. It was observed that the resident required additional precautions. It was observed that while in the resident's room, the PSW was not wearing the required PPE. It was also observed that PSW did not doff PPE upon leaving the room of the resident.

The PSW confirmed they did not don the required PPE while feeding resident. They also confirmed that they did not don and doff PPE. The IPAC lead confirmed it was the expectation for all staff to don and doff the appropriate PPE for additional precautions, when providing care to resident.

Failure to don and doff the required PPE for a resident on additional precautions increased the risk of transmission of infectious disease.

Sources: Observations, interviews with staff. [724]

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The MLTC received a complaint regarding the care of a resident. The complaint was concerning a nurse following the directions for the resident's medication orders. The prescriber changed the administration parameters for the resident's medications. This direction was added to the Medication Administration Record (MAR).

The RPN administered the medication on several occasions to the resident but did not complete a task prior to administration of the medications. The medications were administered despite the metrics were not in the range as specified by the prescriber. The ADORC and the DORC confirmed that nurses are to follow the directions specified by the prescriber. This includes tasks specified by the prescriber. The DORC acknowledged the RPN did not follow the prescriber's directions when they administered the resident's medications.

The resident was at risk of harm when the RPN administered medication when their results were not within the specified parameter.

Sources: Resident's clinical record, MAR, LTCH emails, interviews with staff. [741745]

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

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

Specifically the licensee shall:

1. Provide in-person monitoring and supervision from the nursing management team (Director of Resident Care, Assistant Directors of Resident Care, or non-agency nurse managers) in all home areas during night shift (7:00PM to 7:00AM) once a week, for a period of four weeks, to ensure staff, including agency, adherence with initiation and completion of post-fall assessments including the Neurological Observation Chart for residents who have fallen.
2. Keep a documented record of the management assignments to be present in the resident home areas during night shift; date and time of the audits; name(s) of the registered staff to be monitored/audited; the name of the person conducting the audits; any findings of nonadherence and the actions taken to correct the nonadherence. Make this information available for inspectors upon request.
3. Develop and implement a system for the leadership team (non-agency) to review closed-circuit television (CCTV) video footage of the night shift on a random day each week for a period of four weeks to ensure registered staff are supervising the unit.
4. Maintain a summary of each review, including the date and time, the name of the person conducting the review, analysis of the results of the review and corrective measures implemented if discrepancies are found. Make this information available to inspectors upon request.

Grounds

The licensee has failed to ensure that a resident was not neglected by a Registered Practical Nurse (RPN).

Ontario Regulations 246/22, s. 7 states that "neglect" means 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.

Rationale and Summary

The Long-Term Care Home (LTCH) submitted a Critical Incident Report (CIR) related to an unwitnessed incident and unexpected death of a resident. The resident had an unwitnessed incident and sustained an injury. The resident later passed away.

The RPN assessed the resident post incident and initiated a required assessment for further monitoring. Another RPN was responsible to continue the required assessment and was to complete further assessments during their shift. This RPN filled out the assessment form and they documented that the resident was stable post incident. However, the ADORC who conducted the investigation of this incident discovered that these assessments were not completed.

The ADORC reported that the RPN did not go to the resident's room at the times specified on the assessment form to assess them. Additionally, the RPN took a rest break from the unit for approximately five hours during the night shift. This was confirmed by security camera footage. The ADORC reported that the RPN later admitted that they did not complete any assessments of the resident during their shift. In addition, the RPN admitted the information recorded on the assessment

form was falsified.

The resident's well-being was jeopardized when the RPN neglected to assess the resident after an incident with injury.

Sources: Resident's progress notes, clinical assessments, clinical records. Critical Incident Report, LTCH's investigation notes, security camera footage, interviews with Staff. [741745]

This order must be complied with by April 22, 2024

COMPLIANCE ORDER CO #002 Falls prevention and management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall,
1. Develop and implement a process on all Resident Home Areas (RHA) for the Charge Nurse to co-sign the Neurological Observation Charts each shift for four weeks to ensure the head injury routine is initiated and completed as required for all residents who have an unwitnessed fall or if a head injury is suspected.
2. Nursing Management (non-agency) to conduct weekly audits on all units for four weeks of the home's process to ensure that the Neurological Observation Chart is

initiated and completed as per the home's Fall Prevention and Management Program policy. Analyze the results of the audits and implement corrective measures if discrepancies are found.
3. Maintain a record of the audits, including the date and time, the name of the person conducting the audit, analysis of the results of the audit and corrective measures implemented if discrepancies are found. Make this information available to inspectors upon request.

Grounds

The licensee has failed to comply with their Fall Prevention and Management Program policy related to the monitoring of a resident after an incident with injury.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure that their falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, and must be complied with.

Specifically, staff did not comply with the LTCH's policy related to a required assessment for any unwitnessed fall or if head injury is suspected.

Rationale and Summary

The LTCH submitted a CIR related to an unwitnessed incident and unexpected death of a resident. A resident had an unwitnessed incident and sustained an injury. The resident later passed away.

The home's policy titled Fall Prevention and Management Program, dated July 2023, indicated that registered staff are to initiate a required assessment and complete as per protocol for any unwitnessed fall or if a head injury is suspected.

The required assessment should be completed even if the resident is asleep. The required assessment indicated that a head injury routine must be done for 24 hours. Including vital signs check every 30 minutes for the first 2 hours; every hour for the next 4 hours; every 2 hours for the next 6 hours; and every 4 hours for the next 12 hours.

The RPN assessed the resident post incident and initiated the required assessment. As per the required assessment, the RPN was accountable to complete ten assessments on their shift. However, only 2 out of 10 assessments were recorded on the form. The RPN claimed they had completed the assessments, but they did not record this information in the resident's clinical record. Another RPN was responsible to continue the required assessment and was accountable to complete four assessments during their shift. This RPN filled out the assessment form and they documented that the resident was stable post incident. However, the ADORC who conducted the investigation of this incident discovered that these assessments were not completed.

The ADORC confirmed that the RPN did not complete any required assessments of the resident during their shift. The ADORC reported that the RPN did not go to the resident's room during their shift to assess them. Additionally, the RPN admitted the information they recorded on the required assessment form was falsified.

The ADORC acknowledged that both RPNs did not follow the LTCH's protocol for completing the required assessment for the resident's unwitnessed incident.

Failure to complete the required assessment put the resident at risk as there could be delay in identifying any health changes or injuries as a result of the incident.

Sources: Resident' clinical record, Critical Incident Report, LTCH's investigation

notes, LTCH policy Fall Prevention and Management Program, interviews with staff. [741745]

This order must be complied with by April 22, 2024

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

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.