

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 6, 2020	2020_838760_0029	016797-20	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

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 2, 3, 4, 5, 2020.

The following intakes were completed in this critical incident inspection:

One log was related to an allegation of abuse.

A complaints inspection #2020_838760_0030 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Personal Support Workers (PSW) and the Director of Resident Care (DORC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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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. 23.
Licensee must investigate, respond and act**

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the investigation in an allegation of staff to resident abuse was reported to the Director.

A Critical Incident System (CIS) report was submitted by the home related to an allegation of staff to resident physical abuse. The CIS report did not indicate the outcome of the home's investigation. An interview with DORC #106 confirmed they could not recall updating the CIS report with the results of their investigation.

Sources: A CIS Report; Interviews with DORC #106 and other staff. [s. 23. (2)]

Issued on this 6th day of November, 2020

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

Original report signed by the inspector.