Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# 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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## Public Copy/Copie du rapport public

| 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_0030 | 010795-20, 012133-20 | Complaint |

## 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 Complaint inspection.**

**This inspection was conducted on the following date(s): November 2, 3, 4, 5, 2020.**

**The following intakes were completed in this complaints inspection:**

**Two logs were related to safe and secure home, personal support services and continence care.**

**A CIS inspection #2020_838760_0029 was conducted concurrently with this complaints inspection.**

**During the course of the inspection, the inspector(s) spoke with resident's Substitute Decision Maker (SDM), Activation Aide (AA), Registered Nurse (RN), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), 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**
**Personal Support Services**
**Safe and Secure Home**
**Skin and Wound Care**

**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)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #001's plan of care was followed related to having a designated type of staff member assigned to their care.

A complaint was received related to concerns regarding resident #001, including continence care, that lead to an altered skin condition with the resident. A review of the resident's care plan indicated the resident had specific preferences for the direct caregiver. The resident's progress notes indicated that the resident developed an altered skin condition. A review of the documentation related to continence care during this period indicated that the resident refused care for a number of days on a certain shift, prior to the development of this altered skin condition. The RN indicated that this was due to the fact that the home could not always provide the resident's preferred staff member. As a result, the RN stated they have witnessed the resident to not have received continence care, which lead to the development of their altered skin condition. There was actual harm to the resident, as their plan of care was not followed related to having a designated type of staff member providing continence care to them, which according to the RN, lead to an altered skin condition.

Sources: Resident #001's care plan, progress notes, POC documentation; Interviews with the RN and other staff. [s. 6. (7)]

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**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.**