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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: June 16, 2023

Inspection Number: 2023-1381-0003

Inspection Type:
Critical Incident System

Licensee: Mon Sheong Foundation

Long Term Care Home and City: Mon Sheong Richmond Hill Long Term Care Centre, Richmond Hill

Lead Inspector	**Inspector Digital Signature**
Najat Mahmoud (741773)	Najat Mahmoud Digitally signed by Najat Mahmoud Date: 2023.06.20 14:43:45 -04'00'

Additional Inspector(s)
Elaina Tso (741750)
Lucia Kwok (752) was also present during the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29 to 31, June 1 and 5, 2023
The inspection occurred offsite on the following date(s): June 2, 2023

The following intake(s) were inspected:
- An intake related to an injury of unknown cause
- An intake related to responsive behaviours

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident received a skin and wound assessment upon return from the hospital.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to a resident's injury caused by another resident's inappropriate behaviours. The resident was transferred to hospital after the incident and returned home with an altered skin integrity. There was no documentation that indicated a skin and wound assessment was completed upon their return. The registered and management staff stated that the resident's altered skin integrity needed to be assessed. The management staff further confirmed that a skin and wound assessment was not completed for the resident upon their return from the hospital.

Failure to complete a skin and wound assessment for the resident may lead to potential unidentified skin issues which could result in delay in treatment.

Sources: CIR, resident's health records and interviews with the registered and management staff. [741750]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A CIR was submitted to the Director related to a resident's injury caused by another resident's inappropriate behaviours. The resident was transferred to hospital and returned home with an altered skin integrity. An initial skin and wound assessment was completed for the area right after the incident.

However, there was no documentation of a weekly skin and wound reassessment completed for this area from the initial assessment to when it was resolved. The registered and management staff stated that the injured area was considered altered skin integrity which needed to be reassessed weekly. The management staff further stated that a weekly skin and wound assessment was not completed for the resident's altered skin area.

Failing to complete a weekly skin and wound reassessment for altered skin area put the resident at risk for further skin breakdown.

Sources: CIR, resident's health records and interviews with the registered and management staff. [741750]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, that they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A CIR was submitted to the Director after a resident sustained an injury. The initial interventions to manage the resident's pain included pharmacological and non-pharmacological interventions.

Clinical records indicated that the resident complained of pain on several dates. The resident had a new pain medication prescribed for a week initially and then extended for few more days. There were no pain assessments using a clinically appropriate assessment instrument to monitor and evaluate the effectiveness of the initial interventions.

The registered and management staff confirmed that a pain assessment tool needed to be completed every time a resident complained of pain. The management staff also confirmed that no pain assessments were completed for the resident to evaluate their initial interventions.

Failure to assess and monitor the effectiveness of the initial interventions to manage the resident's pain placed the resident at risk of inadequate pain management.

Sources: CIR, resident's health records, interviews with the registered and management staff. [741773]

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), IPAC Standard section 6.1

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary
In accordance with Additional Requirement 6.1 under the IPAC Standard, the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk.

A PPE caddie was found outside of a resident's room which did not contain all the necessary PPE for staff to perform care. Specifically, eye protection was missing at the point of care.

The management staff confirmed that the resident required additional precautions, and eye protection should have been available in the PPE supply caddie.

Failure to have PPE available and accessible to staff at the point of care, posed a risk of harm to residents and staff from possible transmission of infectious agents.

Sources: Observations, resident's health records, and interviews with the registered and management staff. [741773]