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
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 12, 2024	
Inspection Number: 2024-1381-0001	
Inspection Type: Critical Incident Follow up	
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**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18, 19, 20, 21, 24, 26, 2024.
The inspection occurred offsite on the following date(s): June 25, 2024.

The following intake(s) were inspected:

- One intake related to a fall with injury,
- One intake related to CO #002/ 2023_1381_0004, O. Reg. 246/22, s. 102 (2) (b) IPAC,
- One intake related to CO #001/ 2023_1381_0004, FLTCA, 2021, s. 24 (1) Duty to protect,
- One intake related to physical abuse, and
- One intake related to an incident that caused an injury to resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1381-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Sabra Abubeker (000774)

Order #001 from Inspection #2023-1381-0004 related to FLTCA, 2021, s. 24 (1) inspected by Jennifer Brown (647)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear direction for staff to assist the resident.

Rationale and Summary:
A Critical Incident Report (CIR) was submitted to the Director related to a resident fall that resulted in injury.

A resident's care plan indicated an identified intervention and the use of two different mobility devices.

A review of an order made by the home's physician indicated that one of the mobility devices had been put on hold.

A Personal Support Worker (PSW), confirmed that the resident utilized one identified mobility device.

An interview conducted with a Registered staff member confirmed that the resident did not utilize the identified mobility device noted above.

The Assistant Administrator confirmed during an interview that the resident's identified mobility device was on hold and further indicated that the plan of care for the resident provided unclear direction to staff when the written care plan indicated a different direction.

When direct care staff had no clear direction on how to assist the resident, this placed the resident at an increased risk for falls and injuries.

Sources: Resident's care plan, progress notes, care conference summary, and interviews with PSW, Registered Staff and Assistant Administrator. [000774]

WRITTEN NOTIFICATION: Police Notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident, that the licensee suspected may have constituted a criminal offence.

Summary and Rationale

The Director received a CIR, that indicated a resident reported an allegation of physical abuse.

The progress notes for the resident, indicated that the resident was described as having an "emotional episode" and was found crying. Upon discussion, the resident informed staff about being physically abused.

Review of the CIR and progress notes indicated that after a discussion with the family, the home decided not to contact the police to report the allegation.

The Assistant Administrator, indicated that the home investigated the alleged abuse, however did not report the incident to the police as required by the Fixing Long Term Care Act (FLTCA) as the home did not feel it met the criteria of being reported.

There was a safety risk to the residents when the home did not notify the police immediately related to the allegation of abuse that involved the resident.

Sources: CIR, resident's progress notes, investigation file, and interviews with the Assistance Administrator. [647]

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