

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: December 3, 2024

Inspection Number: 2024-1381-0002

Inspection Type:

Proactive Compliance Inspection

Licensee: Mon Sheong Foundation

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18 to 21, 25, 26, 2024

The following intake(s) were inspected:

- Intake: #00132088 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

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Residents' Rights and Choices
Pain 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 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that different aspects of the plan of care for a resident were integrated and were consistent with and complemented each other.

Rationale and Summary:

The home's skin and wound program was reviewed during a Proactive Compliance Inspection (PCI). A resident's care plan indicated an intervention for their identified skin condition. There was no documented record that the resident received this intervention.

Staff interviewed indicated that the intervention was supposed to be on the Point of Care (POC) documentation system but it was not. Staff confirmed that the intervention was not in the POC because the care plan was not updated by the registered staff.

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Thus, failure of the registered staff to update the resident's plan of care to include the intervention in the POC put the resident at risk for delayed wound healing.

Sources: A resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: O. Reg. 246/22, s. 29 (3) 15.

Plan of care

s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

15. Skin condition, including altered skin integrity and foot conditions.

The licensee failed to ensure that the plan of care must be based on at minimum an interdisciplinary assessment of the resident's skin condition, including altered skin integrity.

Rationale and Summary:

The home's skin and wound program was reviewed during a Proactive Compliance Inspection (PCI). A resident's clinical records were reviewed and indicated that they had an identified skin condition. The resident's care plan did not indicate interventions for this skin condition.

The skin and wound program lead indicated that the care plan was the primary method of communicating the care needs for the residents to the staff and should contain information on residents' skin condition and interventions.

Failure to indicate the residents identified skin condition and interventions in the care plan did not promote healing of their wound.

Sources: A resident's clinical records, Email correspondence, and interviews with the skin and wound program lead.