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

Public Report

Report Issue Date: April 8, 2025

Inspection Number: 2025-1381-0002

Inspection Type:
Critical Incident

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): March 26 -28 and 31, 2025 and April 1-3 and 8, 2025

The following intake(s) were inspected:
An Intake related to a disease outbreak
An Intake related to Injury of unknown origin to resident
An Intake related to Improper care of resident.
An Intake related to Fall of resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee failed to ensure that a specific fall intervention prevention device was applied to the resident as specified in their plan of care.

The resident's care plan indicated that, as part of their safety measures, specific devices were to be on and in working order when the resident was in bed to prevent falls.

The resident had an unwitnessed fall, and the resident's progress note and risk management documentation indicated that no fall intervention prevention device was activated when the resident fell.

Interview with Registered Practical Nurse (RPN) #104, who was present at the time of the incident, confirmed that the fall intervention prevention devices were not functioning at the time of the incident.

Sources: CIR, Resident's Electronic documentation, and interview with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the resident's plan of care was based on an assessment by the physiotherapist (PT).

The resident's clinical records indicated that the PT assessed the resident and recommended using a specific device for transfers. The resident's plan of care was updated the same day; however, it did not reflect the PT's assessment recommendations.

The director of Resident Care (DROC) confirmed that the resident's care plan was not updated to reflect the PT's assessment recommendation.

Sources: CIR, Resident's Electronic documentation, and interview with staffs.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that the resident was treated with courtesy and respect while receiving care.

A Critical Incident Report (CIR) related to the improper care of the resident was submitted to the Director. The resident's clinical records indicated that the resident's Substitute Decision Maker (SDM) found signs of careless care. The home conducted an internal investigation which confirmed PSW #110 provided rough and careless care to the resident.

Sources: CIR, Resident's Electronic documentation, and interview with staffs and home internal investigation note.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC # 004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices and techniques when assisting the resident.
A CIR was submitted to the Director regarding an Injury of unknown origin to the resident. The resident's clinical records indicated the resident was assessed by the PT and recommended the use of a specific device for transfers. The resident's plan of care was updated the same day, but it did not reflect the PT's assessment recommendations.

DROC confirmed that the resident's care plan was not updated to reflect the PT's assessment recommendation, and staff had been using the wrong transferring techniques .

Sources: CIR, Resident's Electronic documentation, and interview with staffs.

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