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: May 15, 2025

Inspection Number: 2025-1636-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Mon Sheong Foundation

Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8, 9, 12-15, 2025

The following intake(s) were inspected:

- An intake related to Resident Bill of Rights
- An intake related to a missing controlled substance.
- A complaint related to alleged discrimination and dining services.

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

Medication Management
Infection Prevention and Control
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 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 a resident was treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality during service provision by a contractor working in the long-term care home (LTCH).

On a specified date, a resident was provided with a requested service resulting in an outcome that was not in keeping with the resident's known preferences. A review of records and interviews demonstrated that there was a breakdown in communication, which led to the resident's right to dignity, respect and courtesy being violated.

Sources: clinical records, investigation notes, interview with LTCH Administrator, interview with resident's SDM. [000745]

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 10.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat.

The licensee failed to ensure appropriate furnishings and equipment in resident dining areas including comfortable dining room chairs and dining room tables to meet the needs of a resident.

A change in furniture was undertaken in a specified resident home area (RHA). The Assistant Director of Resident Care (ADRC) confirmed that no assessment of resident comfort prior to or following the changes had been completed as required.

Sources: Observations, clinical records, the home's complaint record interviews with resident, staff, and ADRC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
3. A missing or unaccounted for controlled substance.

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance for a resident, no later than one business day after the occurrence of the incident.

A Critical Incident (CI) report submitted to the Director indicated that a specified medication had been noted to be missing on a specified date. This was not reported to the Director until one month later.

Sources: CI report, the home's investigation notes, clinical records, and interviews with a Registered Practical Nurse (RPN) and a Registered Nurse (RN).

WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that the home's written policies and protocols were implemented for the medication management system when upon discovery of a discrepancy staff did not report a missing or unaccounted controlled substance immediately.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the medication management system were complied with. Specifically, the home's policy and procedures manual provided by a vendor indicated that upon discovery of a medication incident that staff are to report the incident immediately to the Director of Resident Care and a medication incident report is to be documented prior to finishing the shift.

The resident's controlled drug administration record indicated on a specified day a specified quantity was unaccounted for. Staff that completed the count and recorded the new amount but did not report this discrepancy immediately to a supervisor. Further, other shift counts were edited to reflect the new total. A RPN and a RN both confirmed that when the discrepancy was identified, staff were expected to immediately report this to a supervisor and initiate an incident report.

Sources: CI report, the home's investigation notes, resident's clinical records, Policy & Procedures Manual: medication policy, August 2024, and interviews with a RPN and a RN.

WRITTEN NOTIFICATION: Screening Measures and Ongoing Declarations

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (3)
Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

The Licensee failed to ensure that a VSS had been submitted by a contracted service provider in the home.

During a review of a complaint submitted to the Ministry of Long-Term Care (MLTC) it was noted that a Toronto Police Service (TPS) Criminal Record and Judicial Matters Check form that had been submitted to the LTCH by a contracted service provider had a specification on the form indicating that it was not intended for individuals working in with the vulnerable sector. The LTCH Administrator indicated that the TPS form was the only form of record check included in the former staff member's file and indicated that there was no additional vulnerable sector check (VSS).

Sources: TPS Criminal Record and Judicial Matters Check, interview with Administrator. [000745]

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