Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 26, 2024	
Inspection Number: 2024-1499-0001	
Inspection Type: Critical Incident	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Home for the Aged, Toronto	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 19, 22, 23, 2024

The following critical incident (CI) intakes were inspected:

- Intake: #00097671, injury of unknown cause sustained by a resident
- Intake: #00102567, Infection Prevention and Control (IPAC) related to COVID-19 outbreak

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

Resident Care and Support Services
Infection Prevention and Control

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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
Integration of assessments, 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 has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated.

Rationale and summary

Resident #001 sustained an injury of unknown cause on a specified date.

On a specified date, registered staff was informed by two Personal Support Workers (PSWs) that the resident had impaired skin integrity. The registered staff did not inform other members from the interdisciplinary team in regards to the impaired

skin integrity. The information was also not endorsed to the incoming staff or documented.

Resident #001 continued to present with impaired skin integrity symptoms in the specific area. Several days after the initial report a referral for further assessment was sent to the Physiotherapist (PT), and the Physician. The resident's Substitute Decision Maker (SDM) was informed about the new skin condition.

The PT's assessment indicated an nijury and they recommended further tests and specific limitations in activities of daily living. The test confirmed an injury.

Interviews with two Registered Practical Nurses (RPNs) and the Director of Resident Care Services (DORCS) indicated that the new skin impairment had to be assessed when it was first reported, and referrals should have been sent to relevant interdisciplinary team members for further assessments.

Failure to collaborate on assessing resident #001's impaired skin integrity has placed them at risk for receiving delayed treatment.

Sources: Resident #001's written plan of care, home's investigation record and interviews with the PT and other staff.
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