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

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: June 6, 2024
Inspection Number: 2024-1499-0002
Inspection Type: Complaint Critical Incident
Licensee: Mon Sheong Foundation
Long Term Care Home and City: Mon Sheong Home for the Aged, Toronto

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.06.07 09:57:02 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-17, 22-24, 27-28, 2024

The following Critical Incident System (CIS) intakes were inspected:

- Intake: #00108135 [CIS: 3002-000004-24]- related to a fall
- Intake: #00109301 [CIS: 3002-000005-24] - related to responsive behaviours

The following complaint intake was inspected:

- Intake: #00116068 - related to resident charges, resident care and services, and skin and wound care

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly.

Rationale and Summary

A resident received an assessment for their altered skin integrity. The resident's altered skin integrity was not assessed for two weeks after it was first identified.

The home's Assistant Director of Resident Care (ADORC) stated that staff were expected to complete assessments weekly. The home's lead for skin and wounds at the time, a Registered Practical Nurse (RPN) acknowledged that the assessments should have been completed weekly.

Failure to reassess a resident's altered skin integrity can increase the risk for the staff's inability to assess and monitor the progress of the wound and to determine if further interventions were required.

Sources: Resident's clinical records; Interviews with ADORC and RPN.

[000710]