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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Original Public Report

Report Issue Date: August 1, 2024
Inspection Number: 2024-1499-0003
Inspection Type: Critical Incident
Licensee: Mon Sheong Foundation
Long Term Care Home and City: Mon Sheong Home for the Aged, Toronto

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 22-24, 2024.

The following intake was inspected:
- Intake: #00115420 - [Critical Incident (CI): 3002-000010-24] - was related to fall with inquiry

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

Infection Prevention and Control
Falls Prevention and 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 (7)

Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

The resident's plan of care stated to apply a specified equipment for Activities of Daily Living (ADLs).

A Personal Support Worker assisted the resident with their Activities of Daily Living (ADLs). The resident fell when the PSW turned away from the resident. Record reviews indicated that the PSW did not apply the resident's specified equipment after assisting the resident with their ADLs. This was also verified by the PSW. The resident sustained injuries as a result of the fall.

The Falls Lead, Assistant Director of Resident Care (ADRC) and an Registered Practical Nurse (RPN) stated that the PSW failed to follow the resident's plan of care when they did not apply the resident's specified equipment.

There was harm to the resident when staff failed to follow resident's plan of care, as the resident sustained a fall and injuries.

Sources: Resident's clinical notes; and interviews with staff.