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

Original Public Report

Report Issue Date: October 25, 2024
Inspection Number: 2024-1499-0004
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 onsite on the following date(s): October 10-11, 15-17, 2024

The following intake(s) were inspected:

- Intake: #00121812 - [Critical Incident (CI): 3002-000013-24] - related to infection prevention and control
- Intake: #00126791 - [CI: 3002-000016-24] - related to nutritional care

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
A Personal Support Worker (PSW) assisted a resident with their beverage and failed to perform hand hygiene after resident contact and before removing a soiled cup from another resident. The PSW then immediately proceeded to enter another resident's room without performing hand hygiene.

The PSW acknowledged the inspector's observation and stated that they were required to perform hand hygiene before or after resident/resident environment contact.

Staff's failure to follow proper hand hygiene practices increases the risk of infection

transmission.

Sources: Inspector's observation; and interviews with a PSW and Infection Prevention and Control Lead (IPAC).

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) was followed by the home, in relation to alcohol-based hand rub (ABHR). Specifically, ABHR must not be expired as required by 3.1 IPAC Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Rationale and Summary
The ABHR at the entrance door of a resident's room was observed to have an expiry date of March 2024. This was also verified by a Housekeeper Aide (HA).

The HA nd IPAC Lead both acknowledged that the ABHRs used by the home should not be expired.

Failure to ensure that the ABHR was not expired may have increased the risk of

transmission of infectious microorganisms.

Sources: Observation on October 10, 2024; and interviews with a HA and IPAC Lead.