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
centraleastdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 21, 2022	
Inspection Number: 2022-1381-0002	
Inspection Type: Follow-Up Complaint Critical Incident System	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Richmond Hill Long Term Care Centre, Richmond Hill	
Lead Inspector Nicole Lemieux (721709)	**Inspector Digital Signature** Nicole S Lemieux 2022.11.29 15:02:56 -05'00'
Additional Inspector(s) Ana Best (741722) Asal Fouladgar (751)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 27, 28, 31, November 1 to 3, 2022.

The following intake(s) were inspected:

- An intake related to staff to resident neglect
- A complaint related to staff to resident neglect
- A follow up intake related to plan of care
- A follow up intake related to infection prevention and control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2022-1381-0001 related to FLTCA, 2021, s. 6 (7) inspected by Asal Fouladgar (751)

Order #002 from Inspection #2022-1381-0001 related to O.Reg. 246/22, s. 102 (2) (b) inspected by Nicole Lemieux (721709)

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

Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with O. Reg. 246/22 s. 102 (2) (b), IPAC Standard 9.1 (e)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed related to additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 9.1 (e), the licensee shall ensure that additional precautions, at minimum, include point-of-care signage indicating the appropriate enhanced IPAC control measures that are in place.

Rationale and Summary

Inspector #721709 observed the wrong signage was on a resident's room door for additional precautions. Records provided by the home indicated that a resident in the identified room was under

another type of precautions.

The IPAC Lead confirmed the wrong signage was on the resident's room for the additional precaution. The IPAC Lead immediately removed the incorrect signage from the room and replaced it with the appropriate signage.

Sources: Observations, the Home's updated Line List and interview with IPAC Lead.

Date Remedy Implemented: October 27, 2022 [721709]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with FLTCA 2021, s. 28 (1) 2

The licensee has failed to ensure that suspected neglect of a resident was reported immediately to the Director.

Rationale and Summary:

The home's internal investigation notes indicated that Registered Nurse (RN) #112 received a verbal complaint from a resident's Power of Attorney (POA), alleging Personal Support Workers (PSWs) did not provide personal care to the resident for a long period of time. After the initial complaint, the resident's POA complained to the Director of Resident Care (DORC) about the same allegation. The home contacted the Action Line and submitted a Critical Incident System (CIS) report to the Director the following day.

The DORC acknowledged that the POA's complaint to RN #112 should have been reported to the Director immediately.

As a result of RN #112 failing to report to the Director immediately after becoming aware of the allegation of neglect for the resident, the resident was at risk for further neglect.

Sources: The home's CIR and investigation notes, interviews with the DORC and other staff. [741722]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with FLTCA 2021, s. 6(1)(c)

The licensee has failed to ensure that a resident's plan of care sets out clear direction(s) to staff and others who provide direct care to the resident.

Rationale and Summary:

On an specific date, the home received a verbal complaint from a resident's POA alleging PSWs did not change the resident's personal care product for a long period of time.

The resident's care plan indicated to check and change the resident's personal care product "regularly" and "as needed".

The DORC confirmed the words "regularly" and "as needed", did not provide clear direction to the staff.

Failure to provide clear direction in the resident's care plan regarding a specific aspect of personal care, increases the resident's risk of sustaining injury and infection.

Sources: The home's CIR, resident's clinical records, interview with DORC. [741722]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with FLTCA 2021, s. 6(4)(b)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident, collaborated with each other, in the implementation of the plan of care.

Rationale and summary:
On an identified date, PSW #107 stated that they provided personal care to the resident once during the morning shift, and after dinner time. The PSW stated that personal care was not provided to the resident after lunch as per the resident's POA request. PSW #107 also stated that prior to dinner, clear direction to complete personal care for the resident was not given to staff by the resident's POA. The resident did not receive personal care until the POA requested assistance for the resident after dinner time.

The resident's clinical records indicated that personal care was not provided to the resident from the morning to late afternoon. Furthermore, there was no documentation in the resident's clinical records indicating that the resident's personal care routine had been impacted due to the POA's request.

RN #111 stated no staff member reported to them during their shift that resident's personal care was not provided.

The DORC confirmed that PSWs failed to communicate to the registered nurse that the resident's personal care routine had been affected due to POA's request. DORC acknowledged that there was a need to improve communication between the staff and POA's to prevent further similar incidents.

Failure of the PSWs to collaborate with each other and report changes in the resident's care routine to the registered staff put the resident at risk of injury and infection.

Sources: The home's CIR, resident's clinical records, interviews with the DORC and other staff. [741722]