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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 19, 2022
Inspection Number 2022_1428_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Mon Sheong Foundation

Long-Term Care Home and City
Mon Sheong Scarborough Long Term Care Centre, Scarborough

Lead Inspector
Asal Fouladgar (751)

Additional Inspector(s)
Amandeep Bhela (746)

Inspector Digital Signature
Digitally signed by Asal Fouladgar
Date: 2022.08.24 17:09:03 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 27, 28, 2022, August 2, 3, 4, 2022

The following intake(s) were inspected:

- Intake #010205-22 (Follow-up) related to CO#001, Inspection #2022_595110_0003
- Intake #010206-22 (Follow-up) related to CO#002, Inspection #2022_595110_0003
- Intake #006283-22 related to fracture of unknown cause

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s.3 (1)	2022_595110_0003	001	746
LTCHA, 2007	s. 5	2022_595110_0003	002	746

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

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 (8)]

The licensee has failed to ensure that all staff followed the home's Infection Prevention and Control (IPAC) program.

Rationale and Summary

During the inspection in the home, Inspectors #751 and #746 were informed by the home's Social Worker (SW) that in addition to face masks, all staff and visitors were required to wear eye protection (face shield or goggles) in Resident Home Areas (RHA)s as part of the home's Personal Protective Equipment (PPE) protocol.

In multiple observations, Personal Support Worker (PSW) #100, Registered Practical Nurse (RPN) #103, and Essential Caregivers (ECGs) #125 and #126 were noted not to be wearing eye protections when providing direct care to residents.

PSW #100 and RPN #103 stated they were not aware of the home's PPE protocol related to wearing eye protection. RPN #106 indicated they were told by the home to wear a face shield or eye protection with a surgical mask in RHAs. ECGs #125 and #126 stated that they were aware of the home's PPE protocol and that they were supposed to wear eye protection when in RHAs.

The home's IPAC lead, confirmed that as part of the home's PPE protocol, all staff and visitors were required to apply eye protection (face shield or goggles) when in RHAs.

Failure to adhere to the home's required IPAC practices, would pose a risk to the staff and residents in transmission of infectious agents such as COVID-19 virus.

Sources: Observations on July 28, and July 29, 2022, interviews with PSW #100, RPNs #103 and #106, ECGs #125 and #126, and the home's IPAC lead.

[751]

WRITTEN NOTIFICATION [LICENSEE MUST INVESTIGATE, RESPOND AND ACT]

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

Non-compliance with: LTCHA, 2007 [s. 23 (1) (i)]

The licensee has failed to ensure that an alleged incident of abuse of a resident by anyone was immediately investigated.

Rationale and Summary

A Critical incident System (CIS) report was submitted to the Ministry of Long-term Care (MLTC), related to a resident's injury.

The resident's progress notes, indicated that they stated they had pain to a specific area of their body because someone hit them with an object. The progress notes further indicated that the resident was taken to hospital the next day due to continued pain and it was identified that they had a severe injury to the area which they had pain.

RN #122 stated they were not able to assess the resident when they stated someone hit them, as the resident exhibited resistive behaviour. RN# 122 also stated they did not further investigate regarding the resident's comment.

Director of Care (DOC) confirmed that any allegation of abuse must be investigated as per legislation and the home's abuse policy and that the resident's statement should have been immediately investigated.

Failure to immediately investigate the resident's statement of harm from another person increased their risk of being abused by others and developing injuries as a result.

Sources: Resident's medical records, interviews with RN #122 and DOC.

[751]

WRITTEN NOTIFICATION [DOORS IN A HOME]

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

Non-compliance with: O. Reg. 246/22 , s.12 (1) (3)

The licensee failed to ensure that the soiled room, clean room, and equipment room doors on South Penthouse RHA, soiled room door on Three South RHA and spa room door on Three North RHA were kept closed and locked when not being used by staff.

Rationale and Summary

During an observation on the South Penthouse RHA, the soiled room door, clean room door, and the equipment room door were observed to be unlocked and lodged open with the emergency tag attached to each door.

PSW# 101 approached Inspector #746 and indicated that the doors should have been closed and locked, and that they had propped them open as it was easier to access the rooms. Mechanical lifts, linen carts, and supplies were observed in the rooms.

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

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

A soiled room door was observed to be propped open with the emergency tag on Three South RHA. RPN #108 stated that the door should have been closed and locked, and they pulled away the emergency tag sign allowing the door to close and proceeded to check that it was locked.

A spa room door was observed not to be closed on Three North RHA. RPN #109 acknowledged that the door was not locked and that it should have been locked at all times when not in use.

The Building Service Manager stated that these doors must be closed and locked when they were not being used by staff to ensure residents' safety.

There was potential risk of harm to the residents as the sharps and mechanical lifts were easily accessible in those rooms.

Sources: Observations, Interviews with PSW #101, RPNs #108 and #109, and the Building Service Manager.

[746]