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
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: August 31, 2023	
Inspection Number: 2023-1636-0004	
Inspection Type: Critical Incident System	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville	
Lead Inspector Tiffany Forde (741746)	**Inspector Digital Signature** Tiffany Forde Digitally signed by Tiffany Forde Date: 2023.08.31 10:37:54 -04'00'
Additional Inspector(s) Marian Keith (741757) Lucia Kwok (752) and Colleen Lewis (000719) were present at the inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11, 2023
The following intake(s) were inspected:

- Two Intakes related to falls of residents resulting in significant change in condition.
- One Intake related to disease outbreak

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

Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

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)

The licensee has failed to ensure that a resident with altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

The Director received a Critical Incident Report (CIR) related to a resident's fall resulting in injury. The resident's progress notes indicated they returned to the home with a surgical wound.

There was no documentation in the progress notes that indicated the wound was healed. Further, there were no documentation of weekly wound assessment completed for this wound. A registered staff acknowledged residents with altered skin integrity including surgical wounds, should be assessed once per week and documented in Point Click Care.

Failure to conduct a weekly wound assessment for a resident's surgical wound, prevented the home from monitoring the progression of the wound healing which may have led to a delay in implementing interventions and treatments.

Sources: Resident's clinical record, interview with an RPN

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

The licensee failed to report to Public Health as soon as possible when four residents had symptoms that met the criteria for outbreak according to the home's policy.

Rationale and Summary:

A Critical Incident (CI) was submitted to the Director, informing of a respiratory outbreak in the home. As documented in the home's line list, four residents from the same home area were identified to be exhibiting upper respiratory symptoms. The Infection Prevention and Control (IPAC) Lead confirmed that the cases should have been called in three days earlier to the Public Health Unit.

By not notifying Public Health of cases meeting outbreak criteria when identified, the home was at risk by delaying prompt intervention by Public Health in managing the outbreak.

Sources: Home's Policy, Line listing document, (CI) Report, interview with IPAC Lead.

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