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 District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 31, 2024	
Inspection Number: 2024-1636-0002	
Inspection Type: Critical Incident Follow up	
Licensee: Mon Sheong Foundation	
Long Term Care Home and City: Mon Sheong Stouffville Long-Term Care Centre, Stouffville	
Lead Inspector Natalie Jubian (000744)	**Inspector Digital Signature**
Additional Inspector(s) Fatemeh Heydarimoghari (742649)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 21 to 24, 27, and 28, 2024.

The following intake(s) were inspected:

- Intake #00108682- first follow-up - High Priority Compliance Order (CO) #001 from inspection #2023-1636-0006, related to FLTCA, 2021 - s. 24 (1) Duty to protect, Compliance Due Date (CDD) April 22, 2024.
- Intake #00108683- first follow-up - High Priority CO #002 from inspection #2023-1636-0006, related to O. Reg. 246/22 - s. 54 (1) Falls prevention and management, CDD April 22, 2024.
- Intakes related to outbreaks

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- Intakes related to unexpected death of a resident
- Intakes related to resident fall with injury.
- Intake related to alleged staff to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1636-0006 related to FLTCA, 2021, s. 24 (1) inspected by Natalie Jubian (000744)

Order #002 from Inspection #2023-1636-0006 related to O. Reg. 246/22, s. 54 (1) inspected by Natalie Jubian (000744)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director in relation to a respiratory outbreak.

The Infection Prevention and Control (IPAC) Lead acknowledged outbreaks are to be reported to the Director immediately and confirmed the outbreak had been declared by Public Health a day prior to the submission of the CIR.

Failure to immediately inform the Director on an outbreak, minimizes the potential responses required to manage significant concerns.

Sources: CIR, Interview with IPAC Lead. [000744]