

**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

**Public Report**

**Report Issue Date:** January 31, 2025

**Inspection Number:** 2025-1381-0001

**Inspection Type:**

Critical Incident

**Licensee:** Mon Sheong Foundation

**Long Term Care Home and City:** Mon Sheong Richmond Hill Long Term Care Centre, Richmond Hill

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 22, 23, 24, 27, 28, 29, 30, 2025.

The following intake(s) were inspected:

Critical incident (CI)

Intakes: #00118167- CI# 2897-000011-24/ #00132203- CI# 2897-000025-24 - Two incidents related to residents taken to hospital that resulted in significant change in their health status.

Intake: #00119154- CI# 2897-000013-24- An incident related to an unexpected death of resident.

Intake: #00120603- CI# 2897-000014-24- An incident related to a parainfluenza outbreak in the home.

Intake: #00122053- CI # 2897-000015-24- An incident related to an allegation of staff to resident neglect.

Intake: #00128065- CI # 2897-000019-24- An incident related to an injury of a resident related to a fall.

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

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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: Compliance with manufacturers' instructions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 26**

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that on an unidentified date, staff members used a Handicare portable ceiling tract lift with an Arjo reacher arm, that dislodged from the ceiling lanyard and fell on a resident who sustained an injury.

The manufactures instructions for Arjo portable lift reacher indicated this reacher can only be used for Arjo portable lift devices. This reacher is equipped with an open hook to attach to the ceiling lanyard. The manufactures instructions provided by Handicare, indicated they use a Waverly Glen aluminum reacher arm that has a safety latch that should be used with Handycare portable lifts to prevent the reacher from dislodging from the ceiling lanyard.

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Sources: Interviews staff members, review of resident health care records, the licensee's investigation package, policy and procedure for transfer using ceiling tract lift, the manufacturers instructions from: Handicare AP300/AP450, Waverley Glen aluminum reacher arm user guide and Arjo Portable Lift Reacher.