Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 30, Dec 1, 8, 9, 14, 2011	2011_028102_0028	Critical Incident

Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street, TORONTO, ON, M5T-1J7

Long-Term Care Home/Foyer de soins de longue durée

MON SHEONG SCARBOROUGH LONG TERM CARE CENTRE
2030 Mcnicoll Avenue, SCARBOROUGH, ON, M1V-5P4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

WENDY BERRY (102)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, and an Assistant Director of Care.

During the course of the inspection, the inspector(s) examined lifting equipment; participated in a demonstration on the use of lifting equipment in a resident's bedroom; reviewed documentation and inspection records related to lifting equipment; reviewed "Equipment Usage" training records for 2 personal support workers; reviewed the health record for one resident; reviewed the written statements of 3 staff members; reviewed sections of the Safe Client Handling Program Manual.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Personal Support Services

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. In November, 2011 an identified resident was a resident of an identified room, Mon Sheong Scarborough Long Term Care Centre.

2. The "Resident Care Plan" with a print date of Nov, 2011 was identified to the inspector as being the current care plan for the identified Resident. The plan identifies "Ensure both side rails up when in bed"; "bed rails used for mobility or transfer"; "instruct identified resident to grab the bed rail as staff assist identified resident to turn over"; "lifted mechanically"; "to transfer identified resident to/from bed to wheelchair using Transfer Lift/Ceiling Lift(MEDI-LIFTER); "Two+ persons physical assist".

3. The mechanical lift used to transfer the identified resident on November date, 2011 was identified to the inspector as a portable BHM "Medi-Lifter 4" with serial number as identified. The identified lift was located in the Administration office area at the time of inspection. A "LIFT CERTIFICATION" sticker dated "Aug/25/2011" was affixed to the lift. Service contractor Inspection records specific to the identified lift were provided: "Floor Lift Service Checklist" dated August 25, 2011 and November date, 2011 were reviewed. The lift was not identified in the service records as being defective or unsafe.

4. The sling used to transfer the identified resident on November date, 2011 was present with the lift in the Administration office area at the time of inspection. The sling has labels affixed to it that identify: "BHM Medical Inc."; " Combl Deluxe model"; "use only with BHM Patient lifters"; written on the sling in black marker pen: "Mon Sheong Scarb"; unit identified. A record titled "Mechanical Lift Sling Safety Inspection" "RHA: identified" was reviewed. Inspections of slings are indicated as having been performed once per month from January to November 2011. The condition notes for each month all indicate "OK", with the word "Good" written in the remark column for the months of July and November.

5. The lift manufacturer's "Operating Manual" for the above noted lift was reviewed during the inspection. Page 13 of the manual identifies instructions for "Transferring the Patient": "BEFORE LIFTING THE PATIENT: 1. Make sure that all straps are attached to the spreader bar." The instructions are accompanied by a warning symbol which is identified and described on page 4 of the manual as "intended to alert the user to hazards or unsafe practices, which could result in serious bodily harm." During the inspection, the inspector connected the above noted sling into the connection points on the spreader bar of the above noted lift. The sling loops were latched in place and could not be dislodged when pulled. Safety latches are provided on the spreader bar to prevent sling loops in good condition from coming loose.

6. The home has a "Safe Client Handling Program Manual" which contains policies and procedures. Section 3.5.3.1 titled "Lifting Device" identifies "This procedure requires two caregivers, one on either side of the bed. One is the leader and one is the assistant. 1. Ensure that the lifting device is in good working order and all parts are in place. 2. Check that all lift attachments(ie., slings, hooks, chains,straps and supports)are available, appropriate and the correct size." "9. Lower the bed rails of the bed." "15.Check that all hooks and attachments are secure. 16. Raise the client off the bed slowly with a smooth gentle movement. Pause to allow the client to adjust and to ensure the client feels safe and secure. The assistant on the other side of the bed supports the client's head and shoulders and guides the move through the procedure. If the client is off balance, lower the lift and reposition him/her."

7. Documentation reviewed during the inspection indicates that on November date, 2011 at approximately 07:20 am, the identified resident was being transferred from bed by 2 Personal Support Workers (PSW) using the above identified mechanical lift. The side rail on the left side of the bed, situated next to the lift, had not been lowered during the lifting procedure. The resident was not physically supported by PSW A when the lift was set into motion by PSW B. The PSWs identified that the sling strap closest to the resident's right leg "came loose" when the lift and the resident in the sling were in motion. The identified resident and the
sling holding the resident became "unbalanced"; the identified resident "banged the head on the bedrail on the left side of the bed".

8. Critical Incident Report # received identifies that on November date, 2011 the identified resident sustained an injury during the lifting procedure at approximately 07:20 am; was transferred to hospital at approximately 08:00am. The identified resident's death was certified at the hospital at 16:15pm on November date, 2011.

9. PSW staff failed to use safe transferring and positioning techniques when assisting the identified resident on

November date, 2011.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 21st day of December, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BERRY (102)
Inspection No. / No de l'inspection :	2011_028102_0028
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Nov 30, Dec 1, 8, 9, 14, 2011
Licensee / Titulaire de permis :	MON SHEONG FOUNDATION 36 D'Arcy Street, TORONTO, ON, M5T-1J7
LTC Home / Foyer de SLD :	MON SHEONG SCARBOROUGH LONG TERM CARE CENTRE 2030 Mcnicoll Avenue, SCARBOROUGH, ON, M1V-5P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	STELLA LEUNG

To MON SHEONG FOUNDATION, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee will ensure that all direct care registered and non registered nursing staff use safe transferring and positioning devices and/or techniques when assisting residents by:
1. providing education and re education as necessary on the policy and procedures identified under section "3.5 Client Lifts and Lifting Devices" contained in the Mon Sheong Foundation "Safe Client Handling Program Manual",and
2. ensuring Manufacturers' instructions for the safe use of all resident lifting equipment are understood and followed; and
3. ensuring staff demonstrate their ability to competently and consistently follow the policies and procedures of the home and manufacturers' instructions when assisting residents.

Grounds / Motifs :

1. On November xx, 2011 XX was a resident of room xxx, Mon Sheong Scarborough Long Term Care Centre.

2. The "Resident Care Plan" with a print date of "Nov xx, 2011" was identified to the inspector as being the current care plan for Resident XX. The plan identifies "Ensure both side rails up when in bed"; "bed rails used for mobility or transfer"; "instruct XX to grab the bed rail as staff assist xx to turn over"; "lifted mechanically"; "to transfer xx to/from bed to wheelchair using Transfer Lift/Ceiling Lift(MEDI-LIFTER); "Two+ persons physical assist".

3. The mechanical lift used to transfer resident XX on November xx, 2011 was identified to the inspector as a portable BHM "Medi-Lifter 4" with serial number ---------. The identified lift was located in the Administration office area at the time of inspection. A "LIFT CERTIFICATION" sticker dated "Aug/25/2011" was affixed to the lift. Service contractor Inspection records specific to the identified lift were provided: "Floor Lift Service Checklist" dated August 25, 2011 and November xx, 2011 were reviewed. The lift was not identified in the service records as being defective or unsafe.

4. The sling used to transfer resident XX on November xx, 2011 was present with the lift in the Administration office area at the time of inspection. The sling has labels affixed to it that identify: "BHM Medical Inc."; " Combl Deluxe model"; "use only with BHM Patient lifters"; written on the sling in black marker pen: "Mon Sheong Scarb"; "xx". A record titled "Mechanical Lift Sling Safety Inspection" "RHA: xx" was reviewed. Inspections of slings are indicated as having been performed once per month from January to November 2011. The condition notes for each month all indicate "OK", with the word "Good" written in the remark column for the months of July and November.

5. The lift manufacturer's "Operating Manual" for the above noted lift was reviewed during the inspection. Page 13 of the manual identifies instructions for "Transferring the Patient": "BEFORE LIFTING THE PATIENT: 1. Make sure that all straps are attached to the spreader bar." The instructions are accompanied by a warning symbol which is identified and described on page 4 of the manual as "intended to alert the user to hazards or unsafe practices, which could result in serious bodily harm." During the inspection, the inspector connected the above

noted sling into the connection points on the spreader bar of the above noted lift. The sling loops were latched in place and could not be dislodged when pulled. Safety latches are provided on the spreader bar to prevent sling loops in good condition from coming loose.

6. The home has a "Safe Client Handling Program Manual" which contains policies and procedures. Section 3.5.3.1 titled "Lifting Device" identifies "This procedure requires two caregivers, one on either side of the bed. One is the leader and one is the assistant. 1. Ensure that the lifting device is in good working order and all parts are in place. 2. Check that all lift attachments(ie., slings, hooks, chains,straps and supports)are available, appropriate and the correct size." "9. Lower the bed rails of the bed." "15.Check that all hooks and attachments are secure. 16. Raise the client off the bed slowly with a smooth gentle movement. Pause to allow the client to adjust and to ensure the client feels safe and secure. The assistant on the other side of the bed supports the client's head and shoulders and guides the move through the procedure. If the client is off balance, lower the lift and reposition him/her."

7. Documentation reviewed during the inspection indicates that on November xx, 2011 at approximately 07:20 am, resident XX was being transferred from xx bed by Personal Support Workers (PSW) X and Y, using the above identified mechanical lift. The side rail on the left side of the bed, situated next to the lift, had not been lowered during the lifting procedure. The resident was not physically supported by PSW X when the lift was set into motion by PSW Y. The PSWs identified that the sling strap closest to the resident's right leg "came loose" when the lift and the resident in the sling were in motion. Resident XX and the sling holding xx became "unbalanced"; resident XX "banged xx head on the bedrail on the left side of the bed".

8. Critical Incident Report # ----------11 identifies that on November xx, 2011 Resident XX sustained a xx injury during the lifting procedure at approximately 07:20 am; was transferred to hospital at approximately 08:00am. Resident XX's death was certified at the hospital at 16:15pm on November xx, 2011.

9. PSW staff failed to use safe transferring and positioning techniques when assisting Resident XX on November xx, 2011. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of December, 2011

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : WENDY BERRY

Service Area Office / Bureau régional de services : Ottawa Service Area Office