Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2016	2016_189120_0006-A1	036234-15, 002567-16	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

ALLENDALE
185 ONTARIO STREET SOUTH MILTON ON L9T 2M4

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 9, 2016

Two separate complaints were reviewed during this inspection, one related to the safety of ceiling lifts and one related to the provision of activities for residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Activation Manager, Supervisor of Building Operations, registered staff, personal support workers and maintenance staff.

During the course of the inspection, the inspector toured two separate resident home areas, reviewed the use of the ceiling lifts by personal support workers, tested 6 ceiling lift hand control airlines (cording and connections), reviewed the lift manufacturer's instructions for use and maintenance of the lift, reviewed maintenance records related to lifts, clinical progress notes for one resident, activity calendars for 6 months and rates of resident activity participation.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 23. 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. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that all staff used lift equipment in the home in accordance with manufacturers' instructions.

On a specified date in 2015, a resident was being transferred from their bed to

their wheel chair by two personal support workers using a manually traversing fixed ceiling lift. During the transfer process, the resident sustained an injury. According to both workers, the hand control rubber airline became disconnected from the rubber grommet located on the underside of the motor and fell on the resident. Four small metal ribbed pins were located at the end of the airline which were noted to be quite sharp. The laceration to the resident was suspected to have been caused by the metal pins. According to both workers, no tension was being applied to the airline at the time of the transfer and that the airline "just fell" from the motor. The incident was reported to the registered nurse on the date of the incident who forwarded the concern regarding the loose connector along with 6 others to maintenance on the same date. According to maintenance records, the lifts were reviewed by a maintenance person 3 days later and the response on the work order was "checked all good".

During the inspection, the connection between the airline and grommet on the underside of the motor was tested for a tight connection in the identified resident's room and in four other rooms. Loose connections were noted in the identified resident's room and in three others and were satisfactory in two other rooms. Interviews with various personal support workers revealed that the hand control airlines for various motors had become disconnected in the past and was not uncommon. The workers reported that they reconnected the airline cord to the grommet and continued with the transfer process. The Administrator revealed that training was provided with respect to the appropriate use of the lift and this was supported by the workers interviewed. However, when 2 separate personal support workers were asked to demonstrate the use of the lift, specifically how they moved the motor along the ceiling track from one side of the bed to the other, one used the carry bar and the other used the hand control rubber airline. The Administrator was informed of the loose airline connectors during the inspection at which time she contacted their lift contractor. The lift contractor visited the home on February 10, 2016 and identified that the workers were "not to move the lift using the hand control as the lift was not designed to be moved in that way and that staff should use the strap and carry bar".

According to the manufacturer's user guide for the identified ceiling lift, the rubber airline will become disconnected if the airline is used to pull the motor along the track. According to 3 maintenance staff interviewed in the home, repeated pulling on the airline would impact the connection at the grommet on the underside of the motor over time and contribute to falling airlines when the hand control is used. The ceiling lifts in the home were not motorized and staff therefore were required to move the motor along the track manually. For this type of lift, the manufacturer requires that the motor be be carried

along the track by using the carry bar. The licensee did not ensure that all staff using ceiling lift equipment were using the equipment in accordance with manufacturer's instructions. [s. 23.]

Issued on this 15th day of March, 2016

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

Original report signed by the inspector.