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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 1, 2014	2014_189120_0061	H-001268-14	Critical Incident System

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE, ORANGEVILLE, ON, L9W-3Y3

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): September 24, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Restorative Care Co-ordinator and a Personal Support Worker regarding an incident related to an unsafe transfer.

During the course of the inspection, the inspector(s) reviewed the licensee's records with respect to mechanical floor lift equipment and sling maintenance and inspection records, a resident's health care record, observed the floor lift and sling involved in the incident and obtained copies of the manufacturers' sling use instructions.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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 equipment, specifically slings that accompanied mechanical floor lifts were used in accordance with manufacturers' instructions on a specified date in 2014.

A resident was injured when they were transferred by two personal support workers (PSWs) using a mechanical floor lift and accompanying medium-sized sling. The resident slipped out through the side opening of the sling and sustained an injury.

The resident was identified to weigh 101 pounds (lbs) the day before the incident and confirmation was made that the resident's weight did not exceed 124 lbs within the last year. The PSWs on each shift caring for the resident were directed by management staff (via a written care plan) to use a medium-sized sling for the resident's transfers. The instructions posted on the sling stated that a small sling was to be used for anyone under 124 lbs.

The manufacturers' sling use instructions, which were available in the home at the time of inspection, stated that all 6 straps on the sling were to be used by connecting them to the mechanical floor lift. One of the two PSWs who was involved in the incident reported to the Inspector and Administrator of the home that they used a medium-sized sling for the resident and did not connect all 6 straps of the sling to the mechanical floor lift. Two straps, one located on each side of the sling, in a central location, were not attached. As a result, the resident was not secured into the sling properly and was able to lean out of the sling along one side.

The PSW reported that the training she received in November 2013 regarding the use of the slings did not include any direction to use the centrally located straps. According to the Administrator, an external consultant was hired to provide the sling and lift use training to staff. The Administrator admitted to not reviewing any of the teaching materials used prior to the training as they assumed the trainer was knowledgeable of proper lift and sling use instructions. According to the Administrator, all staff were re-instructed post incident regarding the sling use manufacturer's requirements and residents were in the process of being re-assessed for adequate sling size. [s. 23]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all slings are used in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 6th day of October, 2014

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