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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_204133_0006
Log No. / Registre no:	S-000054-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 12, 2013
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	BELVEDERE HEIGHTS 21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	DONNA DELLIO

To BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST, 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. 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.

Order / Ordre :

The licensee will prepare, submit, and implement a plan for achieving compliance with the requirement that staff use all mechanical lifting equipment in accordance with manufacturers' instructions. Specifically, the plan must outline how all staff will be trained to conduct pre-use inspections before every use of a mechanical lift and associated equipment, such as lifting slings. This is to be based on the manufacturers' instructions, as outlined in the most current user manual for each style of mechanical lift and associated equipment, within the home. This training will cover any/all areas the manufacturer indicates must be verified before every use, such as (but not limited to) instructions to users within the "Daily Check List" section and the "Care and Maintenance – User Inspections" section of the manufacturers' user manuals.

The plan must be submitted in writing to Long Term Care Home Inspector Jessica Lapensée at 347 Preston Street, 4th floor, Ottawa, ON, K1S 3J4. Alternately, the plan may be faxed to the inspector's attention at (613) 569-9670. The plan must be received by March 19, 2013. The plan must be fully implemented by April 8, 2013.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.23 in that staff did not use resident lifting equipment in accordance with manufacturers' instructions.

On a day in February 2013, resident #001 was being transferred from their wheelchair to their bed by two Personal Support Workers (PSWs) using a transfer sling and a Maxi Sky 600 ceiling lift. Manufacturer instructions for this lift are provided by the company known as ArjoHuntleigh. During the transfer,

the cotter pin which secures the lifting strap to the spreader bar fell out. As a result, the spreader bar released. Resident #001 was being held within the transfer sling which was attached to the spreader bar. As reported to the Director of the Ministry of Health and Long Term Care in a Critical Incident report, resident #001 then fell to the floor with the spreader bar landing on top of them. Resident #001 was subsequently transferred to hospital with injury. The resident passed away 14 days later in hospital.

The pin, which secures the lifting strap to the spreader bar, is supposed to be held in place by a split ring. At the time of the inspection, February 26-28, 2013, the corresponding split ring had not been found. The pin that fell out was found by staff following the incident.

During the inspection, on February 26th 2013, the Administrator gave the inspector the Maxi Sky 600 ceiling lift system "Operating and Preventive Maintenance Instructions" manual for review (dated Jan 2005, rev. 0, #001.14150.33). The Administrator explained that this manual came with the lift. Within the "MAINTENANCE" section of this manual, on page 15, the manufacturer outlines 6 procedures that must be followed before each use of the lift. The 6th bullet point reads as follows "ensure the split ring and cotter pin that attach the spreader bar to the strap are secure" . Within the "OPERATION" section of this manual, on page 10, the "How to use the Maxi Sky 600" section begins. The section includes instructions in full sentence form interspersed by boxes which contain warnings, cautions and notes. Warning box #2, between instruction #5 and #6, reads as follows: "MAKE SURE THAT THE SPREADER BAR IS CORRECTLY FIXED. SEE DIAGRAM BELOW:". The diagram shows how the pin goes through the bottom of the lifting strap, within the spreader bar socket, and is fixed in place with the split ring. A picture of the pin through the spreader bar socket without the split ring in place has a circle around it with a diagonal line through the circle, indicating it should not be used if the ring is not present.

The inspector was given policy H7S-5003, "Resident Transfers and Lifts" (revision date December 2012), to review by the Administrator on February 26th 2013 during the inspection. Appendix J of this policy has as its subject title "Mechanical Lifting". Procedure #8 states that the manufacturer's instructions should be followed for safe operation of the lift.

Both PSWs involved in the incident, #S100 and #S101, were independently interviewed by the inspector during the inspection, on February 27th and 28th respectively. Both indicated that they did not know if the split ring was in the pin before conducting the transfer of resident #001 on a day in February 2013 with the Maxi Sky 600 ceiling lift because they did not check for it. They explained to the inspector that lift training they have participated in has not included discussion about this pin and split ring or the need to check for these pieces before using the ceiling lift to transfer a resident. Both staff member #S100 and #S101 informed the inspector that an ArjoHuntleigh trainer was a part of their last lift training session, in June 2011 and November 2012 respectively.

Staff member #S101 is a member of the home's lift training team, which provides lift training for new employees in orientation. Staff member #S101 informed the inspector that lift training sessions that they have been a part of for new employees has not included discussion about the pin and split ring which attaches the spreader bar to the lifting strap nor has it included education about the need to check that these pieces are in place prior to each use of the ceiling lift.

On March 6th 2013, the inspector spoke with the home's training coordinator on the telephone. The training coordinator acknowledged that they themselves were not aware of the pin and split ring in place to secure the lifting strap to the spreader bar on the Maxi Sky 600 ceiling lifts. They confirmed that lift training for staff on the use of the ceiling lifts does not include discussion about these pieces or of the need to check for them prior to lifting a resident with a ceiling lift. The training coordinator also confirmed that ArjoHuntleigh trainers are involved with the delivery of the lift training program to staff at the home.

Staff did not use the Maxi Sky 600 ceiling lift in accordance with manufacturer instructions on a day in February 2013 when transferring resident #001 in that they did not ensure that the split ring and cotter pin that attach the spreader bar to the lifting strap were in place, as per the procedures that must be followed before each use that are outlined in the manufacturers' Operating and Preventive Maintenance Instructions manual (dated Jan 2005, rev. 0, #001.14150.33). (133)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2013

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
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

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

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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 12th day of March, 2013

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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

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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 12, 2013	2013_204133_0006	S-000054-13	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

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

JESSICA LAPENSEE (133)

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): February 26th- 28th 2013

This inspection was in relation to Critical Incident Report # M503-000007-13

During the course of the inspection, the inspector(s) spoke with The Administrator, the Associate Director of Care, a maintenance services staff member, a restorative care aid, a housekeeping services staff member and nursing staff members.

During the course of the inspection, the inspector(s) Reviewed a Critical Incident Report, reviewed documentation related to the investigation into the reported incident, reviewed manufacturer instructions for use of and maintenance of the ArjoHuntleigh Maxi Sky 600 ceiling lift, reviewed ArjoHuntleigh inspection report for all Maxi Sky 600 ceiling lifts within the home, reviewed ArjoHuntleigh service reports for ceiling lift involved in reported incident, reviewed mechanical lift training records for staff involved in the reported incident, reviewed components of a residents health care record, reviewed local hospital emergency record for resident involved in the reported incident, reviewed the ArjoHuntleigh service agreement with the home related to mechanical lift service, reviewed home policies related to resident transferring and use of mechanical lifts, reviewed the home's bi weekly inspection records (year to date) for mechanical lifts throughout the home.

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	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. 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 has failed to comply with O. Reg. 79/10, s.23 in that staff did not use resident lifting equipment in accordance with manufacturers' instructions.

On a day in February, 2013, resident #001 was being transferred from their wheelchair to their bed by two Personal Support Workers (PSWs) using a transfer sling and a Maxi Sky 600 ceiling lift. Manufacturer instructions for this lift are provided by the company known as ArjoHuntleigh. During the transfer, the cotter pin which secures the lifting strap to the spreader bar fell out. As a result, the spreader bar released. Resident #001 was being held within the transfer sling which was attached to the spreader bar. As reported to the Director of the Ministry of Health and Long Term Care in a Critical Incident report, resident #001 then fell to the floor with the spreader bar landing on top of them. Resident #001 was subsequently transferred to hospital with injury. The resident passed away in hospital 14 days later.

The pin, which secures the lifting strap to the spreader bar, is supposed to be held in place by a split ring. At the time of the inspection, February 26-28, 2013, the corresponding split ring had not been found. The pin that fell out was found by staff following the incident.

During the inspection, on February 26th 2013, the Administrator gave the inspector the Maxi Sky 600 ceiling lift system "Operating and Preventive Maintenance Instructions" manual for review (dated Jan 2005, rev. 0, #001.14150.33). The Administrator explained that this manual came with the lift. Within the "MAINTENANCE" section of this manual, on page 15, the manufacturer outlines 6 procedures that must be followed before each use of the lift. The 6th bullet point reads as follows "ensure the split ring and cotter pin that attach the spreader bar to the strap are secure" . Within the "OPERATION" section of this manual, on page 10, the "How to use the Maxi Sky 600" section begins. The section includes instructions in full sentence form interspersed by boxes which contain warnings, cautions and notes. Warning box #2, between instruction #5 and #6, reads as follows: "MAKE SURE THAT THE SPREADER BAR IS CORRECTLY FIXED. SEE DIAGRAM BELOW:". The diagram shows how the pin goes through the bottom of the lifting strap, within the spreader bar socket, and is fixed in place with the split ring. A picture of the pin through the spreader bar socket without the split ring in place has a circle around it with a diagonal line through the circle, indicating it should not be used if the ring is not present.

The inspector was given policy H7S-5003, "Resident Transfers and Lifts" (revision date December 2012), by the Administrator, to review on February 26th 2013 during the inspection. Appendix J of this policy has as its subject title "Mechanical Lifting". Procedure #8 states that the manufacturer's instructions should be followed for safe operation of the lift.

Both PSWs involved in the incident, #S100 and #S101, were independently interviewed by the inspector during the inspection, on February 27th and 28th respectively. Both indicated that they did not know if the split ring was in the pin before conducting the transfer of resident #001 on a day in February 2013 with the Maxi Sky 600 ceiling lift because they did not check for it. They explained to the inspector that lift training they have participated in has not included discussion about this pin and split ring or the need to check for these pieces before using the ceiling lift to transfer a resident. Both staff member #S100 and #S101 informed the inspector that an ArjoHuntleigh trainer was a part of their last lift training session, in June 2011 and November 2012 respectively.

Staff member #S101 is a member of the home's lift training team, which provides lift training for new employees in orientation. Staff member #S101 informed the inspector that lift training sessions that they have been a part of, for new employees, has not included discussion about the pin and split ring, which attaches the spreader bar to the lifting strap nor has it included education about the need to check that these pieces are in place prior to each use of the ceiling lift.

On March 6th 2013, the inspector spoke with the home's training coordinator on the telephone. The training coordinator acknowledged that they themselves were not aware of the pin and split ring in place to secure the lifting strap to the spreader bar on the Maxi Sky 600 ceiling lifts. They confirmed that lift training for staff on the use of the ceiling lifts does not include discussion about these pieces or of the need to check for them prior to lifting a resident with a ceiling lift. The training coordinator also confirmed that ArjoHuntleigh trainers are involved with the delivery of the lift training program to staff at the home.

Staff did not use the Maxi Sky 600 ceiling lift in accordance with manufacturer instructions on a day in February 2013 when transferring resident #001 in that they did not ensure that the split ring and cotter pin that attach the spreader bar to the lifting strap were in place, as per the procedures that must be followed before each use that

are outlined in the ArjoHuntleigh "Operating and Preventive Maintenance Instructions" manual (dated Jan 2005, rev. 0, #001.14150.33). [s. 23.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals. O. Reg. 79/10, s. 219 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s.219(1) in that, apart from the members of the lift training team, staff who use mechanical lifts to transfer residents and were employed prior to 2012 did not receive retraining on the use of mechanical lifts in 2012.

In accordance with LTCHA, 2007, c.8, s. 76(2)11, O. Reg. 79/10, s. 218.2, LTCHA, 2007, c.8, s.76(4) and O. Reg. 79/10, s. 219(1), staff are to be trained before performing their responsibilities and then retrained annually in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibility.

On a day in February 2013, resident #001 was being transferred from their wheelchair to their bed by two Personal Support Workers (PSWs) using a transfer sling attached to a Maxi Sky 600 ceiling lift. During the transfer, the cotter pin which secures the lifting strap to the spreader bar, to which the resident in the transfer sling was attached, fell out. As reported to the Director of the Ministry of Health and Long Term Care in a Critical Incident report, resident #001 then fell to the floor with the spreader bar landing on top of them. Resident #001 was subsequently transferred to hospital with injury. The resident passed away in hospital 14 days later.

Both PSWs involved in the incident, #S100 and #S101, were independently interviewed by the inspector during the inspection, on February 27th and 28th respectively. Staff member #S100 informed the inspector that they had not received mechanical lift retraining in 2012. Their last mechanical lift training session was June 2011. Staff member #S101, who is a member of the home's lift training team, received mechanical lift retraining in November 2012. On March 6th, 2013, the inspector spoke with the home's training coordinator on the telephone. The training coordinator explained that in 2012, all new staff being oriented received mechanical lift training. The training coordinator further explained that it was only the members of the lift training team who received retraining in 2012. All other staff who were employed prior to 2012 did not receive retraining in 2012 as is required. [s. 219. (1)]

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 with the requirement that staff receive annual retraining in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibility., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.90(2)a in that although there are procedures in place, there is no evidence to support that one of the home's MaxiSky 600 ceiling lifts received annual inspection and preventive maintenance by a certified technician as per the manufacturer specifications.

On a day in February 2013, resident #001 was being transferred from their wheelchair to their bed by two Personal Support Workers (PSWs) using a transfer sling and a Maxi Sky 600 ceiling lift. Manufacturer specifications for this lift are provided by the company known as ArjoHuntleigh. During the transfer, the cotter pin which secures the lifting strap to the spreader bar fell out. As a result, the spreader bar released. Resident #001 was being held within the transfer sling which was attached to the spreader bar. As reported to the Director of the Ministry of Health and Long Term Care in a Critical Incident report, resident #001 then fell to the floor with the spreader bar landing on top of them. Resident #001 was subsequently transferred to hospital with injury. The resident passed away in hospital 14 days later.

During the inspection, February 26-28, 2013, the inspector obtained the two following ArjoHuntleigh documents from the home: "Operating and Preventive Maintenance Instructions – Maxi Sky 600 Ceiling lift System" (dated Jan 2005, rev. 0, #001.14150.33), and "Maxi Sky 600, Maxi Sky 600 ECS – Instructions for Use" (dated September 2009, #001.14150.33.EN, rev.5). Within the maintenance section of each manual, page 17 and 41 respectively, it is noted that the Maxi Sky 600 and its accessories must be inspected annually by a certified technician. Each includes a warning box in which it is written "Maxi sky and accessories must be serviced every 12 months as a minimum requirement". An annual load test is to be a component of this annual inspection.

During the inspection, the inspector reviewed the service agreements currently in place between the home and ArjoHuntleigh. The home contracts all service requirements, ceiling lift load testing and annual inspections of its mechanical lifts to ArjoHuntleigh.

The inspector reviewed the service agreement for "TSAL-C certified load test", effective 10/1/12 to 9/30/13, and noted that it included the ceiling lift that was in resident #001's bedroom, with serial # LD131063946. The load test for this ceiling lift was conducted on October 3, 2012.

The inspector reviewed the service agreement for "TSAC Comprehensive", effective 3/1/12 to 2/28/13 and noted it did not include the lift that was in resident #001's bedroom, yet it did include the 13 other Maxi Sky 600 ceiling lifts in the home. The TSAC comprehensive agreement includes preventive maintenance service and annual functional inspection. The inspector reviewed ArjoHuntleigh service call reports dated 03/06/12 and 03/15/12 which were given to the inspector by the Administrator. These reports represent the annual preventive maintenance inspections done in 2012 by the home's ArjoHuntleigh service technician. The inspector noted that the lift that was in resident #001's bedroom was not included within these reports. For other ceiling lifts, the work performed is noted as follows: preventive maintenance/safety audit – completed: full function test, safety audit, accessory audit, PM schedule, safe load test.

The home's Administrator contacted the inspector on March 7th 2013 and informed that a meeting had been held with their ArjoHuntleigh service technician on March 6th 2013. She reported that the technician informed them that it could not be said if the lift #LD131063946 received annual inspection in 2012, as there is no supporting documentation to the effect.

It is noted that in addition to the load test conducted in October 2012, the ceiling lift that was in resident #001's bedroom, #LD131063946, received repairs from an ArjoHuntleigh technician, on 11/15/12 and 01/17/13, related to the lift power supply. [s. 90. (2) (a)]

Issued on this 12th day of March, 2013

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

Jessica Lapensée