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

Division des foyers de soins de longue durée
Inspection de soins 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
Sep 26, 2016	2016_189120_0055	022754-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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): August 18, 2016

#022754-16

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, associate director of care, maintenance person, registered nurses and personal support workers.

During the course of the inspection, the inspector reviewed an identified resident's plan of care, lift and transfer assessments and progress notes, the licensee's mechanical floor lift and transfer policy and procedures, lift maintenance records, observed two staff members in the use of a sling and floor lift, observed the condition of the slings in the home, reviewed sling audit records and staff education and training attendance records for lifts and transfers.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee did not ensure that lift and transfer equipment used to transfer an identified resident was appropriate for the resident based on their condition.

Resident #101 was transferred on a specified date in the summer of 2016 by two personal support workers (PSW) using a sit-to-stand floor lift and a band sling. During the transfer process that occurred in the resident's washroom, staff experienced mechanical difficulties with the lift and the resident had to remain partially suspended over their toilet for several minutes until the PSWs could get assistance and determine how to release the resident from the lift. As the lift did not have an emergency release mechanism, the PSWs and a registered practical nurse (RPN) were prepared to manually assist the resident onto the toilet as the resident was not able to assist with the transfer. According to staff, just before they were prepared to release the straps from the lift, the resident became weak or fainted and released the bars and bent forward at the waist. One staff member reported that the band sling appeared loose and that the

resident's arm slid under it, instead of remaining over the sling, causing the sling to ride upwards towards the resident's shoulders. Two staff members grabbed the resident to prevent them from falling and eased them onto the toilet seat. As a result, the resident sustained an injury and was sent to hospital.

The manufacturer's guidelines for the use of the band sling required that the resident have adequate muscle-tone in their shoulders and lower body. The resident's mechanical floor lift and transfer assessment dated approximately one month prior to the incident identified that the resident required a small band sling, that they had poor ability to stand, poor balance while standing and were not able to bear weight. However, at the end of the assessment, the nurse concluded that the resident required a medium band sling and would be transferred by two staff members using a sit-to-stand lift. These instructions were transferred to the residents' care plan for direction to PSWs.

The licensee's internal policy and procedures (01-03) for use of the sit-to-stand lift clearly identified that the resident must be able to bear weight on at least one limb and that if there was any doubt about the resident's physical status at the time of the transfer process, that a "higher level of assistance" would be required. According to the Director of Care, the full lift should have been implemented which did not require a resident to stand or hold onto the floor lift.

According to a typed referral (Rehab-PT Referral -V2) dated one day prior to the incident and completed by an RN, two PSWs who were assigned to the resident reported to the RN that they had concerns about the resident's ability to be transferred using a sit-to-stand lift. They reported that the resident was no longer able to bear weight and had bilateral weakness and that they were having difficulty transferring the resident with 2 persons. An RN completed an initial assessment of the resident on the same date and maintained that the PSWs could continue to use the sit-to-stand lift with the resident. An assessment was subsequently completed post incident by the Physiotherapist who indicated that a full mechanical lift would be required.

The resident was therefore not transferred using equipment that was appropriate for their condition on the date of the incident. [s. 30. (1) 2.]

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 lift and transfer equipment used to transfer residents is appropriate for their condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that schedules were in place for preventive maintenance related to mechanical floor lifts and slings.

1. A mechanical sit-to-stand floor lift was used to transfer a resident in the summer of 2016. The lift was equipped with a non-removable battery pack which required regular charging. According to staff using the lift, the battery was fully charged prior to use but it ceased while a resident was partially suspended. The lift did not respond when staff plugged it into an electrical receptacle. The lift was not equipped with a mechanical emergency release mechanism. The resident was assisted down from the lift by several staff members. According to documentation provided by the maintenance person, the lift was purchased in 2003, the battery was purchased in May 2011 and the system was inspected by their contracted lift service in April 2015 with no issues. The failure was suspected to be linked to either the age of the battery or a faulty battery. According to the manufacturer's instructions for the lift, the life span of a battery depended on how often it was charged, depth of the discharge (if drained partially vs completely) rest periods between charge and discharge and storage temperatures.

Preventive maintenance records were requested for the specified lift, however the

records provided did not include serial numbers as to which lifts were inspected by internal maintenance staff. The home was noted to have over 12 mechanical floor lifts in use. The licensee's maintenance inspection checklist for the lifts (procedure #6200) included notes that the caster brakes were checked February, April, May and July 2016 and other components in January and March 2016. The procedure identified that the caster brakes were to be checked monthly and all of the other components quarterly. There was no requirement to check the battery. The checklist frequency for the various parts of the lift were not reflective of the manufacturer's suggested frequency schedule which included all components and the battery recharge every 2 months.

2. A random review of slings, which appeared to be ready for use were observed hanging on hooks or on lifts in each home area. One sling was observed in the Wildwood home area, badly ripped along one edge and with a worn out tag. It was taken out of service immediately when identified. In the Glen Williams home area, a Hygiene sling and Hammock sling did not have a date on the labels, and another sling was dated 2009. In the Belfountain home area, two Hammock slings did not have a tag and one was badly ripped along the top seam. Two were also stained yellow and one was odourous.

According to Prism Medical, the supplier of the slings, if the label is not legible or missing, or if the sling is in poor condition (frayed, ripped, stained, torn), the sling should be removed from use. The licensee`s policy RESI-05-06-15 (Mechanical Lifts) required staff to examine slings before using them and to remove immediately from service if defective, worn or faulty. It also directed staff to check slings on a monthly basis and to remove slings that were worn.

The licensee's monthly sling audit form was reviewed but had not been implemented. According to the Associate Director of Care, no formal sling audit was conducted by internal staff whereby the specific sling (using a unique identifier) and date inspected for condition was conducted in 2016. In May 2016, an external contractor was hired to complete a full review of the slings in the home. Approximately 13 slings did not pass inspection for either damage or missing labels. The contractor's report did not include a serial number or unique identifier for each sling inspected. The audit form required that staff label each sling, identify the serial number and that identified that the life span of a sling in constant use was 3 years. [s. 90. (1) (b)]

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 a preventive maintenance schedule is in place for the mechanical floor lifts and slings, to be implemented voluntarily.

Issued on this 26th day of September, 2016

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

Original report signed by the inspector.