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

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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
Mar 17, 2014	2014_178102_0010	000111-14 AND 000130 -14	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 COBOURG
130 NEW DENSMORE ROAD, COBOURG, ON, K9A-5W2

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 System inspection.

This inspection was conducted on the following date(s): February 20 and 27, 2014.

Two Critical Incident Reports (CIR) were reviewed during this inspection: CIR 2851-000003-14 (log # 000111-14) and CIR 2851-000002-14 (log # 000130-14).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident care, the Environmental Services Supervisor, the Advisory Physician, several staff and several residents.

During the course of the inspection, the inspector(s) reviewed 2 CIRs; documentation related to CIRs including the preventative maintenance program and maintenance records; reviewed lift specific operating and product care instructions; viewed a tub lift.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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. Alenti lifts were available for use in several tub rooms in the long term care home up to and including February 05, 2014.

The "Alenti Operating and Product Care Instructions" manual dated April 2004, was available in the home at the time of the inspection on February 20, 2014. The instruction manual was reviewed. Safety warnings are prominently identified with symbols. On page 3 of the instruction manual the safety warning symbol description identifies that "Failure to understand and obey this warning may result in injury to you or to others".

Safety instructions on page 4 of the manual identifies four safety warnings with symbols including "The safety belt must be used at all times to make sure the resident remains in an upright position in the middle of the seat."

Product description instructions for use of the safety belt on page 11 of the manual identifies that "the safety belt must be used at all times to ensure the resident remains in an upright position in the middle of the seat."

Bathing instructions on page 15 of the manual identify instructions for drying the resident after bathing : the resident is to be dried either within the bath tub or when lying on a bed.

Critical Incident Report 2851-000003-14 identifies that during February 2014, a resident had just finished having a bath. Was still in the bath chair - Arjo Alenti. The PSW was drying the resident off when the chair tipped forward causing the resident to fall to the floor. The bath chair fell with the resident...The staff member had just removed the seat belt to dry the residents' back. The castors on the chair were facing out making the chair unstable and caused the chair to flip forward." The CIR identifies that the resident was injured and was taken to hospital.

Staff did not use the lift in accordance with manufacturers' instructions. [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 staff use all equipment, including lifts, in accordance with manufacturers' instructions, 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. (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. At the time of the inspection on February 20 and 27, 2014, policies and procedures had not been developed and implemented to ensure that the ARJO Alenti lifts used in tub rooms were cleaned and maintained at a level that meets the manufacturers' specifications. A "Preventative Maintenance Schedule-Alenti" is contained on page 23 of the Alenti "Operating and Product Care Instructions" manual dated April 2004. Page 24 explains the preventative maintenance schedule.

The schedule identifies 7 "Action/check" points that are to be performed weekly on each lift. It was confirmed by staff of the home that the prescribed checks were not being performed.

It was noted that the lifts are inspected annually by a contractor. [s. 90. (2) (a)]

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 lifts are maintained and cleaned at a level that meets manufacturers' specifications, to be implemented voluntarily.

Issued on this 17th day of March, 2014

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