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
Sep 18, 2014	2014_263524_0032	000607-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
1 Bobier Lane, DUTTON, ON, N0L-1J0

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

BOBIER VILLA
1 BOBIER LANE, DUTTON, ON, N0L-1J0

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

INA REYNOLDS (524)

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 17, 2014.

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care and 3 Personal Support Workers.

During the course of the inspection, the inspector(s) observed resident rooms, reviewed the critical incident, resident health records, staff education records, audits and policies and procedures related to this inspection.

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Documentation review revealed that resident #01 was found by staff to have become entrapped between the mattress and the 3/4 bed rail in place. Care plan review on September 17, 2014 for resident #01 revealed the resident requires the use of side rails when in bed for safety.

The Manager of Resident Care shared that a bed audit was completed by Medical Mart on October 1, 2012 however confirmed that the resident's mattress was replaced after the October 2012 audit. Review of the "Bed Safety – Prevention of Entrapment" draft policy dated July 2014 revealed: "Bed rail use shall be assessed: Whenever a resident changes his/her mattress, bed frame, or any other bed-related products".

There was no documented evidence of a follow up entrapment inspection for the bed with the new mattress. The Manager of Resident Care confirmed that it is the home's expectation that there is immediate reassessment of the bed system when the mattress is replaced for residents requiring bed rails. [s. 15. (1) (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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

Issued on this 18th day of September, 2014

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