Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 20, 2012	2012_072120_0036	Follow up

Licensee/Titulaire de permis

CLARION NURSING HOMES LIMITED
337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7

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

CLARION NURSING HOME
337 HIGHWAY #8, STONEY CREEK, ON, L8G-1E7

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 Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care and Assistant Director of Care regarding the home's bed safety program (H-000682-12)

During the course of the inspection, the inspector(s) toured the 1st and 2nd floor resident rooms and took an inventory of the various bed systems.

A follow-up visit was previously conducted on December 21, 2011 (Inspection #2011-072120-0052) at which time section 15(1)(b) and (c) under Ontario Regulation 79/10 remained non-compliant relating to bed rails and bed mattresses. The home currently has an approved plan, dated May 4, 2012, that outlines the measures being taken to mitigate bed safety risks.

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. 15. Bed rails

Specifically failed to comply with the following subsections:

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;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(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. [O. Reg. 79/10, s.15(1)(b)] The licensee has not ensured that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration, all potential zones of entrapment.

On December 6, 7, & 13, 2011, a bed entrapment audit was conducted by a representative from a mattress supplier on all of the home's bed systems. 39 mattresses were identified with substandard density, a factor contributing to entrapment zone issues. Most of these mattresses are on 29 non-mechanical "old" beds with bed rails that do not latch. During the inspection, the Director of Care reported that mattress stoppers will be installed on all of the remaining 29 "old" beds where mattresses move laterally. She was unable to provide plans as to when or if mattresses would be ordered for the "old" beds to ensure the correct density and therefore reduce risks related to entrapment between the head board and mattress, foot board and mattress and the bed rail and the mattress. On May 4, 2012, the home provided an amended plan indicating that 13 new mattresses are being ordered for the "old" beds and that mattress stoppers will be installed by July 1, 2012.

2. [O. Reg. 79/10, s.15(1)(c)] The licensee has not addressed safety issues related to bed rail latch reliability in the home.

At the time of the visit, bed rails that cannot latch were noted to be in use. Residents in identified rooms were noted to be in bed with either one or both rails in the raised position. Examples were identified where the posted instructions on the walls above the bed stated that rails are to be used for transfers only or that one rail only is to be left raised for repositioning which were not followed. As per the Director of Care, some residents raised the rails themselves. At the time of the inspection, 29 beds remain in the home with latch reliability issues. On May 4, 2012, the home submitted an amended plan indicating that the non-latching rails will no longer be in use once new custom-made rails are delivered and installed July 1, 2012 for the "old" beds.

Issued on this 28th day of May, 2012

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