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

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119 King Street West 11th Floor
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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
Nov 28, 2014	2014_189120_0075	H-000493-14	Follow up

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE NIAGARA FALLS ON L2E 6S5

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.

This inspection was conducted on the following date(s): November 26, 2014

An inspection (2014-201167-0010) was previously conducted March 17-April 1, 2014 and Order #005 issued regarding bed safety and resident assessments with respect to bed rail use. For this follow-up inspection, the conditions laid out in the Order were not fully met. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices regarding residents and bed rail use are derived from a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings". The document has been endorsed by Health Canada and identifies the need to determine the resident`s mobility, medical background, sleeping habits and other factors to establish the benefits of having one or more bed rails in use when a resident is in bed. During the inspection, numerous beds were observed to have at least one bed rail in the elevated position while the bed was unoccupied, a common practice in the long term care industry. Discussions with the Director of Care revealed that it was not the expectation to leave rails elevated and that staff training had not yet been provided. Resident bed rail use assessments were on-going and had not been fully completed. Evidence of the process was confirmed and documentation available establishing the use of the above noted clinical guidance document. The assessments were expected to be completed by the end of November 2014.

The home was previously issued an Order #005 on May 5, 2014 and required to identify by whom and how all residents would be assessed to determine if their bed system was appropriate for their individual needs. The home submitted a plan that identified that once the bed systems passed that the Director of Care would train the Nursing staff on how to conduct assessments for bed entrapment by October 8, 2014. The inspection findings did not support that the actions were implemented by October 8, 2014 or by the date of

the inspection. [s. 15(1)(a)]

2. The licensee did not ensure steps were taken to prevent resident entrapment where bed rails were used on beds that did not pass all zones of entrapment.

Bed systems in the home were tested for entrapment zones on September 29, 2014, following the replacement of 35 mattresses, bed rail tightening, installation of bed rail end caps and mattress keepers. According to the test results provided, all beds passed the required 4 zones of entrapment, whether a regular foam mattress or an air mattress was on the bed frame. Confirmation was made by the Administrator that the data was in fact not accurate for beds with air mattresses and that an editing error occurred when the audit form was updated. The Administrator acknowledged that the air mattresses did not pass any entrapment zone. Air mattresses were identified during the inspection to be very compressible and of a particular design and model that increased the risk of entrapment for residents sleeping on them and if their bed rails were elevated. No interventions such as bed rail pads or bolsters were seen on several of the air mattresses where a bed rail was confirmed to be in use for the resident.

According to the Director of Care, 18 beds with air mattresses were in use by residents and only one or two had interventions in place to mitigate entrapment zone risks where rails were in use. One bed in particular in the 400 wing had a completed evaluation and was equipped with bed rail pads and gap fillers to mitigate several zones of entrapment. She further revealed that interventions would be incorporated only after bed rail use evaluations were completed of the residents. Clarification was provided that risks to residents sleeping on an air mattress and who used a bed rail needed to have some intervention in place to mitigate any potential injuries while the assessments were being finalized. The Administrator identified that accessories were available in the home and would ensure that all remaining residents on an air mattress would be assessed and entrapment zones mitigated by November 28, 2014.

The home was previously issued an Order #005 on May 5, 2014 to identify what immediate actions they could take with respect to safety where one or more entrapment zones did not pass on a bed system. The home submitted a plan that identified that bed rail pads were ordered and bolsters installed and that any bed that did not pass an entrapment zone would be addressed immediately. The inspection findings did not support that the planned actions were implemented. [s. 15(1)(b)]

Additional Required Actions:

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

Issued on this 1st day of December, 2014

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

Original report signed by the inspector.

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0075
Log No. / Registre no:	H-000493-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 28, 2014
Licensee / Titulaire de permis :	MARYBAN HOLDINGS LTD 3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6
LTC Home / Foyer de SLD :	OAKWOOD PARK LODGE 6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LeAnne Ryan

To MARYBAN HOLDINGS LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_201167_0010, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

1. The licensee shall mitigate any identified entrapment zone risk(s) for all residents who have been provided with a therapeutic air mattress and who use or have one or more bed rails elevated.

2. The licensee shall assess each resident in accordance with prevailing practices identified as "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" for bed rail use and include the information in the residents' plan of care (indicating at a minimum the number of rails used, the size, the side and for what reason).

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices regarding residents and bed rail use are derived from a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings". The

document has been endorsed by Health Canada and identifies the need to determine the resident`s mobility, medical background, sleeping habits and other factors to establish the benefits of having one or more bed rails in use when a resident is in bed. During the inspection, numerous beds were observed to have at least one bed rail in the elevated position while the bed was unoccupied, a common practice in the long term care industry. Discussions with the Director of Care revealed that it was not the expectation to leave rails elevated and that staff training had not yet been provided. Resident bed rail use assessments were on-going and had not been fully completed. Evidence of the process was confirmed and documentation available establishing the use of the above noted clinical guidance document. The assessments were expected to be completed by the end of November 2014.

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residents and only one or two had interventions in place to mitigate entrapment zone risks where rails were in use. One bed in particular in the 400 wing had a completed evaluation and was equipped with bed rail pads and gap fillers to mitigate several zones of entrapment. She further revealed that interventions would be incorporated only after bed rail use evaluations were completed of the residents. Clarification was provided that risks to residents sleeping on an air mattress and who used a bed rail needed to have some intervention in place to mitigate any potential injuries while the assessments were being finalized. The Administrator identified that accessories were available in the home and would ensure that all remaining residents on an air mattress would be assessed and entrapment zones mitigated by November 28, 2014.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2014

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.

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 28th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

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