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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2015	2015_189120_0053	H-002270/002271-15	Follow up

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF WENTWORTH HEIGHTS
1620 UPPER WENTWORTH STREET HAMILTON ON L9B 2W3

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): July 9 & 16, 2015

An inspection (2015-201167-0004) was previously conducted January 28-February 12, 2015 and Orders 001 and 002 were issued for non-compliance related to bed safety and resident immunizations. For this follow-up visit, all of the conditions laid out in Order 002 were met. Order 001 was not fully met, and the remaining condition has been identified below.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Physiotherapist and Infection Control Lead/Neighbourhood Co-ordinator. The Inspector toured the home and observed residents and resident bed systems, reviewed the home's bed safety audit results, resident care plans, immunization documentation and available information with respect to resident clinical bed safety assessments.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2015_201167_0004	120
O.Reg 79/10 s. 229. (10)	CO #002	2015_201167_0004	120

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 residents were assessed in accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

According to the Neigbourhood Co-ordinator (NC) who was responsible for organizing the bed safety program in the home, a formal assessment tool or form was not developed to document how each resident was evaluated to determine if one or more bed rails were appropriate and safe for use. The development of the tool was a requirement of the licensee in an Order issued during an inspection conducted in February 2015. According to the prevailing practices document identified above, how the home staff arrived at their conclusions, what questions were asked, what characteristics and resident habits were reviewed, what alternatives were trialled and what interventions were implemented should be included in a formal clinical assessment. At the time of inspection, confirmation was made through interviews and documentation that all residents were evaluated by a physiotherapist, registered staff and the NC to determine if the residents required a bed rail for positioning, mobility, transfers or fall prevention. This information was documented in the resident's plan of care, however 4 out of 7 identified plans reviewed on July 9, 2015 did not include how many rails were required and on what side of the bed. The clinical assessments of the residents to date were not fully completed and the NC reported that the assessments were being completed in 3 phases.

The bed safety audit that was completed by the NC in May 2015 identified that approximately 40% of their bed systems did not pass all zones of entrapment and that the beds, regardless of what interventions were installed (mattress keepers, new mattress or tightening of the bed rails), were not able to pass 2 specific zones. The NC reported that each resident who required or requested a bed rail for their assessed need and were at high risk for entrapment, were provided with a hi/low electric bed that passed all zones of entrapment. The remaining residents using a bed rail in failed beds were at low risk for entrapment based on their mobility and cognition. All residents are slated to be re-evaluated on a continuous basis as part of the home's bed safety program and if necessary, entrapment risk will be further mitigated with the installation of a bed rail pad or gap filler after further evaluations to determine the safety of the accessories. The specific details regarding what further evaluations are to be completed, what criteria will be used and whether accessories are necessary have not been included in any formal documentation. The majority of the assessment data acquired to date was stored on an electronic spread sheet kept by the NC and not the residents' plan of care. The NC reported that the development of a formal document is forthcoming and would include an interdisciplinary approach. [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, residents are assessed in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 20th day of July, 2015

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

Original report signed by the inspector.