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
Jul 7, 2014	2014_217137_0017	L-000508-14	Follow up

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

THE MAPLES HOME FOR SENIORS
94 William Street South, P.O. Box 400, Tavistock, ON, N0B-2R0

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

MARIAN MACDONALD (137)

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): June 17, 2014

Follow-Up to L-000150-14 with Inspectors # 120 and # 515

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

During the course of the inspection, the inspector(s) conducted a tour of the home and reviewed relevant policies, procedures and documents.

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 failed to ensure 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, as evidenced by:

Observations, during a tour of the home on June 17, 2014, revealed:

(1) Therapeutic surfaces for five identified beds were not secured to the bed frames, with security straps as provided by the manufacturer. There were no bed rails or bolsters in place.
(2) The two ¼ bed rails for an identified resident were loose and the bed rails pulled away from the bed, when bed was in the lowest position, posing a potential bed entrapment risk.
(3) There was movement of ¼ bed rails for an identified resident, posing a potential bed entrapment risk.
(4) On an identified bed, the mattress slides on the bed frame, is not secured with corner mattress keepers, the bolster is not securing the mattress at the end of bed and the bed wheels do not lock at head of the bed, causing bed movement.
(5) Assessments have not been completed to ensure the interventions implemented mitigate risks to residents that use one or more bed rails, for beds that failed any zone of entrapment.

The Administrator and Director of Care confirmed the previous order had not been fully complied with and the expectation is that all required measures will be implemented to ensure 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. [s. 15. (1)]

Additional Required Actions:

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

Issued on this 7th day of July, 2014

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