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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2015	2015_189120_0023	H-001822-15	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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 27, 2015

An inspection (2014-189120-0075) was previously conducted on November 26, 2014 at which time Order #001 was issued for bed safety and resident assessments. The conditions in the order were met, however additional were identified. See below for details.

issues

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care. The Inspector toured the home and randomly observed residents in bed and reviewed their bed rail use assessment records.

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)
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	2014_189120_0075	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, steps were taken to prevent resident entrapment specifically on beds where a low air loss surface was applied, taking into consideration all potential zones of entrapment.

During the previous inspection conducted in November 2014, the licensee was in the process of assessing their residents for bed rail use and had not instituted all necessary interventions to reduce or mitigate all entrapment zones. During this inspection, the Director of Care (DOC) confirmed that all residents had been assessed for bed rail use but not all residents who required a bed rail had the appropriate evaluations to determine if interventions instituted were effective or whether each resident received adequate interventions on beds equipped with a low air loss surface. The DOC confirmed that there were 22 beds with an air loss surface in use by residents during an audit of the beds on January 9, 2015.

During the inspection, six identified beds were observed to have a low air loss inflating surface on the bed. Bed rail use instructions were posted on a chart in resident rooms for staff to follow. Three beds in particular were visually examined and hand tested and appeared to have areas of entrapment between the bed rail and mattress. Documents reviewed (plan of care, bed rail assessment, bed entrapment audit report) did not include whether zones of entrapment 2,3 and 4 had been adequately measured and/or mitigated on these beds. According to the Director of Care, it was probable that some beds with an air loss surface were not measured after bed rail pads were installed to determine their effectiveness in addressing any identified gaps.

The following observations were made during the inspection;

A) One identified bed had both 3/4 rails elevated and both were in use by the resident, but only one rail was padded and no gap fillers were provided. When tested, the mattress was pushed down and away from the rail without much effort. The posted chart in the residents' room indicated that the resident required both rails when in bed. No bolsters or additional bed rail pads were available in the room.

B) One identified bed was unoccupied, but the posted chart in the room identified that both 3/4 rails were to be used. Only 1 rail was padded and no additional bed rail pads or bolsters were observed on the bed or in the resident's space. The soft and flexible nature of the low air loss surface presented a gap between the mattress and the non-padded rail when pushed down.

C) One identified bed was unoccupied but had both rotating assist rails elevated. The posted chart identified that the resident was required to have both rails up when in bed. Neither rail was padded and no bolsters were on the bed or located in the resident's space. The rail was tested and could be pulled away from the bed, leaving a large gap along side of the mattress.

Discussion was held with the Director of Care and Administrator regarding the need to confirm whether all interventions instituted to date were effective in reducing entrapment gaps in zones 2, 3 and 4 and that documentation is kept of the interventions applied. [s. 15(1)(b)]

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, steps are taken to prevent resident entrapment specifically on beds with low air loss surfaces, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

Issued on this 8th day of April, 2015

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

B. Sosnik

Original report signed by the inspector.