



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Dec 16, 22, 2011; Feb 7, 2012 | 2011_105130_0034 | Complaint

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

GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, staff and residents related to H-002508-11

During the course of the inspection, the inspector(s) interviewed staff, residents, reviewed clinical records and observed care

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

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



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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>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.)</p> | <p>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.</p> |
| <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following subsections:

- s. 29. (1) Every licensee of a long-term care home,
 - (a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
 - (b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee did not ensure that the policy to minimize restraining of residents is complied with. The home's policy "CN-R-05-5 Restraints" indicates: Staff apply the physical device in accordance with any manufacturer's instructions. The manufacturer's instructions provided by the Director of Care regarding positioning belts indicates they must not be too loose as to allow residents to slide under the belt. In 2011 an identified resident was found on the floor next to the bed; the wheelchair was positioned next to the resident and the reverse fastening seatbelt on the wheelchair was still fastened.

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 the policy to minimize restraining of residents is complied with, to be implemented voluntarily.

Issued on this 7th day of February, 2012

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

