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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
May 8, 2014	2014_189120_0025	H-000244-13	Follow up

Licensee/Titulaire de permis

VIGOUR LIMITED PARTNERSHIP ON BEHALF OF VIGOUR
302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - TULLAMORE
133 KENNEDY ROAD SOUTH, BRAMPTON, ON, L6W-3G3

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): April 24, 2014

An inspection was previously conducted on April 16, 2013 (2013-189120-0026) related to bed safety. An Order was issued at the time for non-compliance. For this visit, the conditions of the Order have been met, however additional issues were identified and are described below.

During the course of the inspection, the inspector(s) spoke with the Environmental Services Supervisor and Associate Director of Care regarding bed safety.

During the course of the inspection, the inspector(s) conducted a random tour of resident rooms and observed resident bed systems, tested resident bed side rails for general condition, reviewed the home's bed entrapment audit results, resident bed rail use assessment forms and resident care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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 did not evaluate residents in accordance with evidence-based practices to minimize risk to the resident, where bed rails are used.

The licensee completed resident assessments in May 2013 following an inspection conducted on April 16, 2013. According to the Associate Director of Care (ADOC), the tool that was used to guide her was titled "Side Rail and Alternative Equipment Intervention Decision Tree" dated 2001. Three possible outcomes listed on the tool led her to a decision to have the residents' bed rails removed in most circumstances. It did not include an interdisciplinary approach to a final decision nor did it incorporate many of the questions identified in the current best practices. The resident assessments were completed once and have not been on-going as required and none of the information about bed rail details were made available in the residents' care plans. In particular, two identified residents were observed sleeping in bed with both of their assist rails in the engaged position on April 24, 2014. Both residents required assistance to reposition and turn while in bed by staff and one required cuing to use the side rails. Neither plan stated that the resident required two rails engaged at all times and the reason.

The ADOC did not believe that the assessment tool she used incorporated the US Food and Drug Association Guideline titled "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings, April 2003". The guideline has been endorsed by Health Canada and is currently the only document with comprehensive information regarding bed safety and bed rail use. The ADOC agreed that removing the bed rails may not be the best solution and stated that they had not yet removed them. The guideline refers to minimizing or not using the bed rails but does not suggest that they be completely removed for various reasons. Resident's health, mobility and cognitive status changes on a regular basis and therefore bed rail needs will change and should be made readily available when necessary.

During the inspection, bed rails were observed and confirmed to be affixed to beds and in many cases, the rails were observed in the horizontal or assist/guard position, centrally located along the bed length on unoccupied beds. When the ADOC was shown the engaged bed rails, no specific reason could be given as to why the rails were engaged. [s. 15(1)(a)]

2. The licensee did not address other safety issues related to the use of bed rails.

During the inspection, many loose rotating assist bed rails were identified on resident's beds, creating a potential entrapment risk and an unstable transfer device for residents who use the rails for assistance when getting into or out of bed.

In January 2014, the licensee had their bed system supplier complete a bed entrapment audit of all but 8 beds. It is unknown why the 8 beds were not tested at the time but all of the other beds passed the essential entrapment areas known as zones 1-4. In discussion with the Environmental Services Supervisor (ESS), he had already made arrangements for the bed supplier to visit the home on May 20, 2014 to complete another bed entrapment audit.

As resident bed systems were observed and compared to the entrapment audit, some of the bed side rails were noted to be spaced too far away from the mattress sides. The assist rails were observed in three different positions, completely down, raised in a vertical position near the head of the bed (transfer position) or raised in a horizontal position in the centre of the bed (guard or assist position). Rails identified in 8 rooms were loose and 2 in particular had large gaps (over 4 inches) between the rail and the mattress when in the raised vertical position. Once the rails was rotated to the horizontal position, the gap was reduced, but the rail could be moved back and forth without effort. It was identified that some bed models had a slightly different type of assist rail and a different type of metal attachment plate and were therefore much more stable and without gaps. [s. 15(1)(c)]

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 all safety issues are addressed with respect to the use of bed rails, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there are schedules and procedures in place for routine, preventive and remedial maintenance related to bed equipment.

The licensee did not have at their disposal any of the manufacturer's guidelines for the care and maintenance of their bed models. The manuals are required to identify the frequency of inspections for the various components of the bed, including bed side rails. No schedules had been developed for routine inspections and staff had not identified that any of the bed rails were loose to the maintenance department as part of their remedial maintenance program.

On April 24, 2014, resident bed systems were observed with loose side assist rails and in some cases the rails were spaced too far away from the mattress sides. The assist rails, which were able to rotate 180 degrees, were observed in three different positions, completely down, raised in a vertical position near the head of the bed (transfer position) and raised in a horizontal position in the centre of the bed (guard or assist position). Rails identified in 8 resident rooms were loose or identified to have large gaps (over 4 inches) between the rail and the mattress when in the raised vertical position. Once the rails was rotated to the horizontal position, the gap was reduced, but the rail could be moved back and forth without effort. It was identified that some bed models had a slightly different type of assist rail and a different type of metal attachment plate and were therefore much more stable and without gaps. The ESS and ADOC were both informed of the rooms where loose rails were observed at the time of inspection and neither were previously aware of the situation. [s. 90(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 there are schedules and procedures in place for routine, preventive and remedial maintenance related to bed equipment, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
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	2013_189120_0026	120

Issued on this 20th day of May, 2014

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

B. Susnik