Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 7, 8, 20, 2012	2012_029134_0015	Critical Incident

Licensee/Titulaire de permis

MAXVILLE MANOR
80 Mechanic Street, MAXVILLE, ON, K0C-1T0

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

MAXVILLE MANOR
80 MECHANIC STREET WEST, MAXVILLE, ON, K0C-1T0

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse (RN), a Registered Practical Nurse (RPN) and several Personal Support Workers (PSW)

The on-site critical incident inspection log # O-001890-12 was conducted November 8 and 9, 2012.

During the course of the inspection, the inspector(s) reviewed the resident's health record, critical incident and internal incident reports, assessed the resident's bed rails, reviewed the Neurological Assessment Protocol and the Fall Prevention and Management Policy.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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
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 subsections:

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;
(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. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the O. Reg. 79/10 section 15 (1) c, in that the latch on resident #1's bed is not always reliable.

Resident # 1 was found on the floor on the right side of the bed after having fallen out of bed on August 13, 2012 at 14:20h. The progress notes were reviewed. There is an entry indicating the following: "Resident was found lying on the floor in prone position. Resident had previously been in bed with bilateral rails up. Resident sustained a head injury with abrasion to forehead and bruising on dorsal aspect of both hands".

Resident #1's bed rails were assessed by Inspector #134 on November 8, 2012. At the time of the inspection, it was observed that the mattress was not centered in the bed causing the mattress to prevent the right bed rail from latching-on easily. It was observed that the right bed rail stayed up without the latch as it was sitting on top of the mattress and blankets.

PSW # S101, who was on duty the day of the fall was interviewed and reported that he/she was aware that the right bed rail was usually difficult to latch on due to the mattress and bed sheets being snug against the right bed rail.

Issued on this 20th day of November, 2012

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

Colette Asselin, LTC Inspector #134