



**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
prévus 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
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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
Feb 28, Mar 1, 5, Apr 4, 10, 2012	2012_072120_0020	Critical Incident

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

POST INN VILLAGE
203 Georgian Drive, OAKVILLE, ON, L6H-7H9

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

BERNADETTE SUSNIK (120)

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, Manager of Resident Care and Maintenance Co-ordinator regarding bed systems(H-000219-12)

During the course of the inspection, the inspector(s) reviewed maintenance bed inspection logs, bed manufacturer's instruction manual, observed the resident's bed and several other resident beds, observed maintenance staff demonstrate how beds are inspected for entrapment zones and reviewed the resident's plan of care.

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



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Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.)
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 90. Maintenance services

Specifically failed to comply with the following subsections:

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,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee has not ensured that there are schedules and procedures in place for routine, preventive and remedial maintenance. The maintenance program as it relates to ensuring that resident beds and mattresses are maintained in a safe condition and in a good state of repair is not preventive for all beds and mattresses. The Maintenance Co-ordinator and Manager of Resident Care provided information that beds and mattresses are inspected only on admission, before internal transfers, when a therapeutic mattress or mattress change was required or when an alteration was required. The MC Healthcare Products Inc. bed instruction manual requires that certain bed components be inspected semi-annually. The bed inspection log provided at the time of inspection did not identify on what date the beds/mattresses were inspected and did not identify a unique identifying mark or serial number for the bed inspected. Beds that had deficiencies or risks associated with them did not have any follow-up action documented.

The home developed a new policy titled "Bed Inventory and Entrapment Assessment Procedure" dated January 10, 2012 that entails the process for bed inspections and it includes a frequency of inspections to include a preventive component for all beds.

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care



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Specifically failed to comply with the following subsections:

- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
- (a) a goal in the plan is met;
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c.8, s. 6(10(b))] The licensee has not ensured that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

The residents plan of care did not include an assessment with respect to safety risks associated with her therapeutic mattress.

An identified resident sustained an injury in 2012 when a limb became trapped between an air mattress and the bed rail. The resident received the therapeutic mattress in 2010. The resident's plan of care references that the mattress is therapeutic but does not list any safety risks associated with its use. The plan of care states that both bed rails are to be used when the resident is in bed for "safety reasons" but does not specify the safety reasons. The mattress supplier conducted a bed safety inspection in 2011 and concluded that "no entrapment risk was identified". However, the home's maintenance staff conducted their own assessment post injury and determined that several entrapment zones existed, especially between the bed rail and the air mattress. The home took immediate action and had the supplier provide the resident with raised side protection bolsters and bed rail padding which prevent the resident's arms or legs from falling off the mattress surface and getting lodged between the bed rail and the frame. The plan however has not been revised post incident and does not include any assessment, re-assessment information or the interventions put in place to maintain resident safety as a result of the incident.

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 10th day of April, 2012

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