Ontario

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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 27, 2019	2019_745690_0021	005295-19	Follow up

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Coleman Care Centre
140 Cundles Road West BARRIE ON L4N 9X8

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

TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 20-22, 2019.

The following intake was inspected upon during this Follow Up Inspection:

-One log, related to CO#001 from Inspection report #2019_745690_0002, regarding s.15 (1) of the Ontario Regulations 79/10, specific to the use of bed rails.

Critical Incident inspection #2019_745690_0022 was conducted concurrently with this Follow Up Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Care (DNC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the Inspector(s) conducted a daily tour of the resident care areas, observed beds in the home, and reviewed internal documents.

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)**
- **0 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	2019_745690_0002	690

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On March 1, 2019, the following compliance order (CO) #001 from inspection number 2019_745690_0002 was made under O. Reg. 79/10, s. 15 (1), related to bed rails was issued:

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.
Specifically, the licensee must:
1. a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Specifically, the bed systems are to be evaluated for zones 2, 3 and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.
b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side, and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).
c) Where bed rails do not pass zone 2, 3 or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.
d) Inspect each bed when conducting bed system evaluations for condition as per the manufacturer's recommendations (castor brakes, remote, manual cranks, head and foot board condition, mattress condition, bed rail condition).
e) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching

Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).
f) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.
g) Keep accurate and detailed records as to what was done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).
h) Amend or update policy 06-02 entitled "Bed Entrapment and Bedrail Assessment" to include a reference to "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

The compliance due date was June 28, 2019. A request to extend the compliance due date until July 19, 2019, was approved.

While the licensee completed steps a-f, and h, in CO#001, the licensee failed to complete step g.

Inspector #690 requested the records for the bed evaluations completed on all beds in the home. The Inspector reviewed the bed evaluation record and noted that the record included a bed identifier number and information on the type of mattress and the condition of the mattress however, did not include a mattress identifier. A further review of the bed evaluation records indicated that an identified bed had a specified type of mattress.

During an observation of beds in the home, Inspector #690 identified that the identified bed had a different type of mattress than the one that was specified on the bed evaluation record. The Inspector could not locate a mattress identifier on the mattress.

During an interview with the Director of Nursing Care (DNC), they indicated that the identified bed was evaluated with the mattress that was on the bed and could not say why the list was incorrect. The DNC indicated that the home previously had mattress identifiers on the mattresses, but after the purchase of some new mattresses, they no longer had a mattress identifier system in place. The DNC identified that CO#001 the home had received had instructed the home to keep accurate records of the bed evaluations including having a mattress identifier. The DNC further indicated that the record of the bed evaluation of the identified bed was not accurate and that there was no

mattress identifier listed on the evaluation and that there should have been. [s. 101. (3)]

Issued on this 29th day of August, 2019

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

Original report signed by the inspector.