Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor

Telephone: 416-325-9297
1-866-311-8002
Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair ouest, 8ième étage
Ottawa ON K1S 3J4

Téléphone: 416-325-9297
1-866-311-8002
Télécopieur: 416-327-4486

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'Insptection
September 21, 2010	2010_101_9573_21Sep110406	CIS Follow-up (107(3)(4))

Licensee/Titulaire

Corporation of the County of Simcoe, 1110 Highway 26, Midhurst, ON L0L 1X0

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

Simcoe Manor Home for the Aged, 5988- 8th Line , Main Street East, P.O. Box 100 Beeton, ON L0G 1A0

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

Amanda Williams (101)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Mandatory Report/Critical Incident Inspection following a resident injury with transfer to hospital.

During the course of the inspection, the inspector spoke with the Director of Care, Nurse Manager, Personal Support Workers, and registered nursing staff.

During the course of the inspection, the inspector: measurements of the bed and mattress where the incident occurred were taken and the resident's health care records were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
2 CO: CO #001, #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c). Every licensee of a long-term care home shall ensure that,**
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings:

1. On the date of inspection, a resident's therapeutic mattress was not secured to the bed frame therefore allowing it to shift from side to side creating various size gaps between the bedrail and mattress. The gap between the bedrail and mattress created a potential entrapment hazard:
   a) Deflated air mattress: 4 inches between mattress and right bedrail
   b) Inflated air mattress: 2 ½ inch gap at top and 3 ½ inch gap at bottom of mattress and right bedrail.

Inspector ID #:	101

Additional Required Actions:

None

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b). 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,**
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) the care set out in the plan has not been effective. 2007, c.8, s. 6 (10).

Findings:

1. The plan of care does not address a resident's repetitive high risk actions.

Inspector ID #:	101

Additional Required Actions:

None

WN #3: The Licensee has failed to comply with **O. Reg 79/10 s. 15(1)(a)(b). 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.

Findings:

1. A resident's risk for limb entrapment was not mitigated.
2. On the date of inspection September 21, 2010, a resident's therapeutic mattress was not secured to the bed frame allowing the surface to shift from side to side creating various size gaps between the bedrail and mattress. The gap between the bedrail and mattress created a potential zone 3 entrapment hazard as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"*:
   a) Deflated air mattress: 4 inches between mattress and right bedrail
   b) Inflated air mattress: 2 ½ inch gap at top and 3 ½ inch gap at bottom of mattress and right bedrail.

Inspector ID #:	101

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #4: The Licensee has failed to comply with **O. Reg 79/10 s. 48(2)(b). Each program must, in addition to meeting the requirements set out in section 30,**
(b) provide for assessment and reassessment instruments.

Findings:

1. The home does not have a fall assessment and reassessment instrument.

Inspector ID #:	101

Additional Required Actions:

None

WN #5: The Licensee has failed to comply with **O. Reg 79/10 s. 49(1). The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.**

Findings:

1. The home's fall prevention and management program was not effective in mitigating a resident's falls and other risk actions.

2. The Home's documentation stated an identified resident's bed alarm was attached to the sheets and therefore not effective in activation of the alarm when the resident got out of bed.
3. On the date of inspection a resident's therapeutic mattress was not secured to the bed frame, therefore allowing it to shift from side to side creating various size gaps between the bedrail and mattress. The gap between the bedrail and mattress created a potential entrapment hazard:
   a) Deflated air mattress: 4 inches between mattress and right bed rail
   b) Inflated air mattress: 2 ½ inch gap at top and 3 ½ inch gap at bottom of mattress and right bed rail.

Inspector ID #:	101

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #6: The Licensee has failed to comply with **O. Reg 79/10 s. 49(2). Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.**

Findings:

1. A post fall assessment was not completed on a resident following a fall and subsequent transfer to hospital.
2. The home does not have a clinically appropriate assessment instrument that is specifically designed for falls.

Inspector ID #:	101

Additional Required Actions:

None

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: DOC Date: Sept. 30. 10	Date of Report (if different from date(s) of inspection). September 30, 2010

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

Name of Inspector:	Amanda Williams	**Inspector ID #**	101
Inspection Report #:	2010_101_9573_21Sep110406		
Type of Inspection:	CIS Follow-up (107(3)(4))		
Licensee:	Corporation of the County of Simcoe, 1110 Highway 26, Midhurst, ON L0L 1X0		
LTC Home:	Simcoe Manor Home for the Aged, 5988- 8th Line , Main Street East, P.O. Box 100 Beeton, ON L0G 1A0		
Name of Administrator:	Hilary Mallet		

To Corporation of the County of Simcoe, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: **O. Reg 79/10 s. 15(1)(a)(b). 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.

Order:

The licensee shall develop a plan to ensure all beds in the home, including those with therapeutic mattresses and bedrails are maintained in safe condition and free from all potential zones of entrapment. The licensee shall submit the plan to this inspector at the above noted address.

Grounds:

1. On the date of inspection a resident's therapeutic mattress was not secured to the bed frame creating a shifting of the surface and the development of gaps between the bedrail and mattress. The gap between the bedrail and mattress was between 2 ½ to 4 1/2 inches creating a potential entrapment hazard and unsafe conditions.

This order must be complied with by:	October 15, 2010

IO – 08/12 4:20 pm

Order #:	002	Order Type:	Compliance Order, Section 153 (1)(b)

Pursuant to: **O. Reg 79/10 s. 49(1). The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.**

Order:

The licensee shall develop a plan to mitigate and reduce the falls of all resident's at high risk for falls. The licensee shall submit the plan to this inspector at the above noted address.

Grounds:

1. The home's fall prevention and management program was not effective in mitigating falls and risk behaviours of an identified resident.
2. Incorrect positioning of safety devices (i.e. bedrail and bed alarm), therefore rendering them ineffective was noted for an identified resident.
3. On the date of inspection a resident's mattress was not secured to the bed frame creating gaps and potential entrapment hazards between the mattress and bedrail.

This order must be complied with by:	October 29, 2010

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28

days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 30th day of September, 2010.	
Signature of Inspector:	A. Williams
Name of Inspector:	Amanda Williams
Service Area Office:	Toronto