Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2020	2019_830752_0004	020121-19	Follow up

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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 ou des inspecteurs

LUCIA KWOK (752), AMANDA COULTER (694)

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): December 16, 17, 18, and 19, 2019.

The following intake was completed during this Follow up inspection: Log #020121-19/ Follow up to CO#001 related to the assessments of bed rails and their bed systems.

During the course of the inspection, the inspector(s) spoke with residents, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Supervisor (ESS), and Maintenance Staff.

The inspectors also toured the home, observed the provision of care, observed resident and staff interactions, reviewed pertinent clinical records, reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 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 failed to ensure that where bed rails were used for residents, residents were assessed and their bed systems were evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the residents.

A follow up inspection was conducted for compliance order #001 from inspection #2019_545147_0011.

A) Director of Care (DOC) #100 stated that the Dementia Observation System (DOS) sleep study was completed to assess and determine the residents' need for bed rails. Registered staff were to complete the study every hour for three consecutive days before and after the application of bed rails.

Long-Term Care Homes (LTCH) inspectors#752 and #694 observed that resident #002's bed had specific bed rails in place and an identified mattress type as part of their bed system.

The “DOS charting – Bed Rail Project” study was initiated for resident #002 on a identified date. The document was blank and there were no entries. A hand written note stated that the resident required the specific bed rails for safety.

Resident #002’s care plan indicated that the purpose of the specific bed rails was for safety.

Assistant Director of Care (ADOC) #108 stated that the home's practice was to put specific bed rails on bed systems with identified safety risks.

B) The home's policy titled, "Bed Entrapment A-10", last revised December 2019, stated that all bed systems would be audited annually and when new bed systems are installed. The policy referred to a supporting document titled, "Bed Entrapment Testing Procedure, Task #ESS-001", last revised December 2019. The document specified that annually, the Environmental Services Supervisor (ESS) would measure for zones of entrapment for all beds and mattresses in the home and document the results on the "Resident Bed/Mattress Entrapment Audit".

Maintenance staff #109 stated that the document titled, "Bed Measurement Device Test Results Worksheet" was used for entrapment zone testing and the testing was completed whenever there was a change to the bed system. Furthermore, they stated that the bed entrapment assessments for residents #001, #002, and #003 were completed by a summer student who no longer worked at the home.

It was observed that resident #001 had a specific bed rail on their bed system. Personal Support Worker (PSW) #102 and the care plan stated that resident #001 used the bed rail to assist with specific activities of daily living. According to the Bed Measure Device Test Results Worksheet for resident #001's bed system, not all potential zones of entrapment were tested, and the area where the bed rail was currently being used had not been evaluated.

It was observed that resident #002 had specific bed rails and an identified mattress type on their bed system. LTCH inspector #694 observed that there was a gap in between the mattress and the bed rail. The bed system did not have any equipment to minimize the risk of entrapment to the resident. The Bed Measurement Device Test Results Worksheet for resident #002's bed system was incomplete as not all potential zones of entrapment were assessed.

On an identified date, ADOC #108 sent maintenance staff a Bed/Mattress Change Form request for resident #002. Changes were made to the bed system to mitigate the risk to the resident.

It was observed that resident #003 had a specific bed rail on their bed system. PSW #106 stated that resident #003 used the bed rail for specific activities of daily living. According to the Bed Measure Device Test Results Worksheet for resident #003's bed

system, not all potential zones of entrapment were tested, and the area where the bed rail was currently being used had not been evaluated.

Maintenance Staff #109 said that the bed safety assessment test did not evaluate all potential areas of entrapment. In the case of resident #002, there were no steps taken to minimize risk of entrapment between the specific bed rails and the identified mattress type on their bed system. They stated that the worksheets for residents #001, #002, and #003 had incorrect information.

C) DOC #100 provided the LTCH inspectors with a bed rail tracking sheet titled, “Simcoe Manor Resident List Report”. The tracking sheet listed residents’ identifying information with the corresponding number of bed rails and status of the bed rails they used. There was no documentation of the auditing process to track the use of bed rails, no indication of assessments and reassessments on this tracking sheet.

ESS #105 provided the LTCH inspectors with a blank template titled, “Resident Bed/Mattress Audit Form” and said the form would be implemented in the year 2020. DOC #100 stated that the bed rail reassessments were to be completed annually, at care conferences. The DOC acknowledged that the home was to implement the auditing process for residents who used bed rails but only starting in January 2020.

The licensee failed to ensure that resident #002 was assessed for the use of their bed rails and the bed systems for residents #001, #002 and #003 were evaluated in accordance to evidence-based practices to minimize the risk to the residents. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LUCIA KWOK (752), AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2019_830752_0004
Log No. / No de registre :	020121-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 15, 2020
Licensee / Titulaire de permis :	Corporation of the County of Simcoe 1110 Highway 26, Midhurst, ON, L9X-1N6
LTC Home / Foyer de SLD :	Simcoe Manor Home for the Aged 5988 8th Line, Main Street East, P.O. Box 100, Beeton, ON, L0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janina Grabowski

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_545147_0011, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 15 (1) (a) and (b).

Specifically the licensee must:

a) Ensure that resident #002 and any other residents that have bed rails are assessed. The results of the residents' assessments should be documented.

b) Ensure that the bed systems for residents #001, #002, #003 and any other residents that use bed rails are evaluated in accordance to evidence-based and prevailing practices to minimize the risk to the residents. The results of the bed system assessments should be documented together with any recommendations.

c) Ensure that staff who are involved in the assessment of bed rails and bed systems have been trained in accordance with the Health Canada Guideline, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" and evidence-based and prevailing practices. This training should be documented and records kept available in the home.

d) Ensure that an auditing process is developed and fully implemented to track the use of bed rails, bed system assessments and reassessments. The auditing process must be documented and include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken. The audit should be kept available in the home.

Grounds / Motifs :

1. 1. The licensee failed to ensure that where bed rails were used for residents, residents were assessed and their bed systems were evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the residents.

A follow up inspection was conducted for compliance order #001 from inspection #2019_545147_0011.

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for bed rails. Registered staff were to complete the study every hour for three consecutive days before and after the application of bed rails.

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On an identified date, ADOC #108 sent maintenance staff a Bed/Mattress Change Form request for resident #002. Changes were made to the bed system to mitigate the risk to the resident.

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annually, at care conferences. The DOC acknowledged that the home was to implement the auditing process for residents who used bed rails but only starting in January 2020.

The licensee failed to ensure that resident #002 was assessed for the use of their bed rails and the bed systems for residents #001, #002 and #003 were evaluated in accordance to evidence-based practices to minimize the risk to the residents.

The severity of this issue was determined to be a level 2 as there was minimal risk of harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the O.Reg. 79/10 and three or fewer compliance orders that included:

• compliance order (CO) #001 issued October 8, 2019 with a compliance due date of November 1, 2019 (2019_545147_0011).
(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2020

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lucia Kwok

Service Area Office /
Bureau régional de services : Central West Service Area Office