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

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Original Public Report

Report Issue Date: April 2, 2024
Inspection Number: 2024-1240-0001
Inspection Type: Critical Incident
Licensee: Genesis Gardens Inc.
Long Term Care Home and City: Foyer St-Viateur Nursing Home, Limoges
Lead Inspector Lisa Kluke (000725) — **Inspector Digital Signature**
Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 11 and 12, 2024

The following intake was inspected:

- Intake: #00097056 was related to a fall that resulted with a significant change in condition for a resident.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed rails

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 18 (1)

Bed rails

s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and the resident's 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.

The licensee has failed to ensure that where bed rails are used, that the resident was assessed, their bed system is evaluated for zones of entrapment and safety issues were addressed including height and latch reliability to minimize risk to a resident.

Rationale and Summary:

A resident had an unwitnessed fall from their bed with a specified type of bedrails on each side of the bed on a specified date and sustained an injury.

This resident's electronic and paper health care records were reviewed to their admission date, and no documentation of any assessment of this resident to require the use of bedrails were located. The resident's plan of care indicated to use two bed-rails up when in bed for falls/balance needs as they were a high risk for falls.

The Director of Care indicated that they could not locate any records regarding this resident being evaluated to need bed rails.

A restorative care staff member completed the resident's bed system measurement device test results worksheet on a specified date three months before the resident's fall. This worksheet indicated the resident had passing results for a different type of bed rail system and not for the resident's bed rail system used with their specified type of mattress. A post fall assessment package was reviewed for a fall four days prior to the critical incident, when the resident fell from their bed, which indicated as an intervention that an adjustment was required for their specified mattress. After this mattress adjustment the resident's bed system was not reevaluated for zone entrapment.

The restorative staff member indicated that they were not aware of the need to verify the bed rail latch reliability or the bed rail height. Restorative care staff member indicated 26 of 41 beds in the home had bed rails or bed helpers attached. Eight of the 26 beds with rails were being used as Personal Assistance Service Device (PASD)/Restraint according to the Director of Care.

Failing to accurately assess this resident's need for their bed rail and completing an evaluation of their bed system for entrapment zones as well as an assessment of height and latch reliability of all bed rails used with resident's beds, posed potential risk for injury for the residents who were at high risk of falls from their beds.

Sources: a resident's health care records reviewed, interviews with restorative staff and the Director of Care. [000725]

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented.

Rationale and Summary:
A resident sustained an injury post fall from their bed on a specified date. A post fall assessment was completed four days earlier, for a similar fall from their bed, that indicated a revision of the resident's plan of care for falls interventions to increase the monitoring of the resident when in bed or to bring them closer for supervision and monitoring when agitated to prevent re-occurrence. This post fall assessment was revised by the Director of Care in place at the time on the day prior to the critical incident.

The Current Director of Care indicated changes to the resident's plan of care were done manually on paper.

The resident's plan of care indicated that they required the regular monitoring and documentation of the resident when in bed with their bed rails in place.

The PSW that responded to the resident's fall on this specified date and time

indicated they had last assessed the resident according to their regular evaluation needs. This PSW reported the resident's plan of care was to monitor and document regularly when the resident is in bed. The PSW was not aware of any need to increase monitoring or to get them up if they were agitated. The PSW indicated the resident was on the floor at their bedside with a visibly crooked leg and the resident's bed rail remained in place.

Falls Prevention Program for post fall assessment and management policy and procedure page 4, last revised February 2019, that was in place at the time of the resident's fall, indicated to ensure all fall preventive measures are applied to prevent further falls, to modify the resident's plan of care and the Director of Care and/or designate will review all incident reports and documentation for accuracy of data entry, preventative measures in place and follow-up care outcomes.

Failing to follow their policy and procedures and implement changes to the resident's plan of care for this increased monitoring when in bed potentially contributed to the resident's fall whereby the resident fell from their bed and sustained an injury four days later.

Sources: Resident's health care record review and interviews with a PSW and the current Director of Care. [000725]