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 30, 2019	2019_573581_0011	010930-19, 010932-19, 013412-19	Critical Incident System

Licensee/Titulaire de permis

Shalom Manor Long Term Care Home
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

Shalom Manor Long Term Care Home
12 Bartlett Avenue GRIMSBY ON L3M 4N5

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 31, August 1, 2, 6 and 7, 2019.

The following Critical Incident System inspections were completed:
log #010932-19 - related to falls management;
log #010930-19- related to falls management;
log #013412-19- related to falls management.

During the course of the inspection, the inspector(s) spoke with Interim Chief Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and residents.

During the course of the inspection, the inspector reviewed clinical health records, observed the provision of care and reviewed relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed.

A. Review of the clinical health record identified that resident #003 fell on an identified date in July 2019 and sustained an injury.

Review of the written plan of care identified the resident was transferred and ambulated with an identified level of assistance. The resident required a specific device for ambulation and staff were to monitor the resident.

During an interview with PSW #106, they stated resident #003 was on a specific mechanical lift for all transfers in and out of bed, was no longer walking or using the specific device since they fell and sustained an injury.

Following a review of the plan of care with RN #107, they confirmed resident #003 was no longer walking with a specific device and was transferred in and out of bed with a specific mechanical lift.

The plan of care was not reviewed and revised when the resident's care needs changed after their injury.

B. Review of the written plan of care identified that resident #003 had a specific device in place as a falls intervention.

On an identified date in August 2019, the resident's room was observed with two specific devices in place.

During an interview with RPN #105, they stated the resident's bed was moved after the resident fell and required two specific devices in place.

RPN #105 confirmed the plan of care was not reviewed and revised when the resident's care needs changed.

C. Review of the clinical health record identified that resident #003 fell on an identified date in July 2019, sustained an injury and required a specific intervention.

Review of the Transfer and Repositioning Assessment, identified the resident required a specific mechanical device with an identified level of assistance in and out of bed.

In an interview with PSW #106, they stated the resident was transferred in and out of bed with the specific mechanical lift with an identified level of assistance after the specific intervention was completed. The transfer status was changed to another specific mechanical lift but they were not able to recall who assessed the resident for the change or when the transfer status was changed.

Review of the written plan of care identified the resident was a specific transfer with an identified level of staff assistance.

Following a review of the plan of care with the ADOC, they stated that on an identified date in July 2019, a note from registered staff was documented that the resident #003 was a specific mechanical lift in and out of bed; however, confirmed that a Transfer and Repositioning Assessment was not completed by registered staff when the resident's transfer status improved.

The ADOC confirmed the plan of care was not reviewed and revised when the resident's care needs changed.

D. A review of the clinical health record identified on an identified date in July 2019, resident #005 fell and sustained an injury. A device was put in place to manage the injury.

Review of the progress notes on an identified date in July 2019, identified that resident #005 had two injuries and their weight bearing status changed.

A review of the Transfer and Repositioning Assessment dated July 24, 2019, identified the resident was transferred on and off the toilet with an identified level of staff assistance and the resident was able to assist.

Review of the plan of care identified the resident was toileted with an identified level of assistance.

During an interview with PSW #108 and #109 they stated the resident was transferred in and out of bed with a specific mechanical lift with an identified level of assistance; however, were transferred for toileting with a specific device followed by specific

instructions.

Following a review of the plan of care with RPN #110, they confirmed the resident had a specific weight bearing status for all transfers. The Transfer and Repositioning Assessment was to be completed with any significant change in condition and the plan of care should have been updated.

The plan of care was not reviewed and revised when the resident's care needs changed.

E. Review of the clinical record identified that resident #005 fell on an identified date in July 2019, which resulted in an injury.

On an identified date in August 2019, resident #005's room was observed with specific falls interventions in place.

In an interview with PSW #108, they stated the resident had specific falls interventions, which had been in place since the resident fell and sustained an injury.

During an interview with RPN #110, they stated the resident did have the specific devices in place as fall interventions to manage the resident's falls; however, confirmed the plan of care was not reviewed and revised when the resident's care needs changed.

F. Review of the current written plan of care identified resident #005 used a specific device for transferring in and out of bed and required an identified level of assistance for bed mobility.

In an interview with PSW #109, they stated the resident had two specific devices that were used to assist the resident with bed mobility. They stated the resident required more assistance for bed mobility due a specific device.

Following a review of the plan of care with RPN #110, they stated resident #005 required two specific devices to assist with bed mobility and an identified level of assistance after they fell and sustained an injury.

RPN #110 confirmed the plan of care was not reviewed and revised when the resident's care needs changed after their injury. [s. 6. (10) (b)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

Issued on this 6th day of September, 2019

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

Original report signed by the inspector.