Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 5, ~~6, 15, 20, 26,~~ 2012	2012_189120_0007	Critical Incident

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with administrator, assistant director of care, corporate nursing consultant and non-registered staff.

During the course of the inspection, the inspector(s) toured several resident rooms, reviewed resident bed and mattress styles, reviewed the home's policies and procedures on bed rail use and prevention of bed entrapment, resident health care records, assessments, employee statements and bed audit reports. (H-002128-12)

The following Inspection Protocols were used during this inspection:

Falls Prevention

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

Findings/Faits saillants :

[O. Reg. 79/10, s. 15(1)(b)] The licensee of a long-term care home has not ensured that where bed rails are used,

(b) steps have taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

The home had an external contractor conduct an entrapment bed safety audit September 6, 2012, however the audit did not include beds with air mattresses. The home's air mattress supplier conducted an inspection on resident #001's bed and four other beds on September 27, 2012. However, the inspection did not include a bed safety audit of entrapment zones 2-7. Due to the nature of an air mattress (those without bolsters or mattress perimeter stabilizers), they do not pass zones 2-4 when bed rails of any length are used.

During the inspection, documentation which was provided by the home did not include any safety assessments of residents using an air mattress and bed rails. Resident #001 who was admitted in 2012 was provided a bed with two bedrails and an air mattress. On a specified date 2012, the resident's bed was replaced with a bed with quarter rails. No decision tool was used on either occasion to determine the entrapment risks and how to mitigate them nor were alternatives considered (assist rail, bolsters, no rail use).

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

[O. Reg. 79/10, s. 26(3)10.] The licensee of a long-term care home did not ensure that the plan of care is based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident:

10. Health conditions, including allergies, pain, risk of falls and other special needs.

Resident #001 received a fall's assessment 5 days after their admission in September 2012 which revealed a high falls risk. The resident's plan of care printed on November 5, 2012 did not identify the resident's risks of falling or specific interventions in place to manage this identified need.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

[O. Reg. 79/10, s. 30(2)] The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #001, upon admission in 2012 was assessed to be immobile, at risk of falls and needing assistance with turning and repositioning while in bed. The resident was provided with two bed rails which were to be applied as a Personal Assistive Service Device so that the resident could grasp the rail and assist with turning. In 2012, the resident received a new bed with smaller rails as the staff felt he would be at risk with the longer bed rails. Staff revealed that the resident was becoming more active in bed. A worker documented on November 2012 that the resident was attempting to get out of bed.

Staff did not document the reassessment of the resident's needs at the time of the bed change.

Issued on this 26th day of November, 2012

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

B. Sosnik