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
May 31, Jun 6, : 2012	2012_072120_0046	Critical Incident

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

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 the Executive Director, Director of Care and registered staff.

During the course of the inspection, the inspector(s) viewed the identified resident's room and bed system, reviewed the resident's plan of care and progress notes and the home's policies and procedures on falls prevention and bed safety. (H-000703-12)

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)(a)] The licensee of the long-term care home did not ensure that where bed rails are used,

(a) the resident was 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;

An identified resident received an 11 inch thick therapeutic air mattress in 2012 for medical reasons. Neither the resident or the air mattress was assessed to determine if it would pose any safety risks to the resident or if it was a good fit for the frame of the bed and not pose entrapment hazards with bed rails in use. In 2012, the resident slipped off the mattress and fell onto a hard floor surface. A falls arrest mattress was located on the opposite side of the bed.

Following the incident, the mattress distributor was contacted by registered staff to determine if the resident's mattress could be made more comfortable. The representative identified that the air pressure was too high and decreased it by 50% and ordered a thinner mattress. A Registered Nurse made a note that a discussion was held at the time that the thinner mattress would "make the partial side rails more effective and would deter the resident from trying to get out of bed unassisted". The resident received an 8 inch thick mattress several weeks later which was verified at the time of the inspection.

It was verified that the air mattress the resident fell from was inappropriate for the bed frame. The air pressure of the air mattress was high, creating a stiffer mattress surface and therefore causing the resident to sit higher up on the mattress. The surface of the mattress was higher than the top level of the bed rail and the rail would have been completely obscured by the air mattress. The rails were documented as being in the up position, however the bed rails would not have served their intended purpose. The staff documented that the bed was in the lowest position, however when taking into consideration the height of the mattress surface (11 inches), the thickness of the bed frame (2 inches) and the bed in the lowest position (Approx. 5 inches above ground level), the resident fell from a height of approximately 18 inches.

The home hired a contracted service to conduct an entrapment zone assessment in 2011 for all beds with foam mattresses. Fifteen of these beds did not receive an assessment because the beds had air mattresses on them. Residents residing on these air mattresses require very specific assessments which were not conducted.

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 where bed rails are used, the resident and his or her bed system is evaluated in accordance with evidence-based practices or prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c. 8, s. 6(7)] The care set out in the plan of care is not provided to the resident as specified in the plan.

An identified resident's bed was observed to have a quarter rail or "assist" rail on either side of their bed, located at the head of the bed. The resident was not in bed at the time of the observation. Confirmation was made with registered and non registered staff that the resident always has bed rails in place, during the day and at night and staff could not provide a particular purpose for the use of bed rails. Progress notes made before and after falling incidents in 2012 indicate that a tumble mat or falls arrest mat was placed beside the resident's bed to reduce the potential for injury. The resident's plan of care does not address bed rail use or the use of a tumble mat.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c.8, s.8(1)(a)] Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act.

The home, which is required to have a falls prevention and management program did not implement all aspects of their program. The home's falls risk assessment policy and procedure #N-5-70 dated January 31, 2005 requires that the registered nurse conducts a falls assessment on residents upon admission and annually or when necessary. The policy includes an assessment tool which would be completed by the nurse. As confirmed by the Director of Care and the resident's clinical record, the identified resident did not have a falls assessment conducted in 2011 at the time of admission, or after falling twice in 2012.

Issued on this 13th **day of July, 2012**

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

B. Smith