Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: November 14, 2023	
Inspection Number: 2023-1127-0003	
Inspection Type: Critical Incident	
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	
Long Term Care Home and City: Niagara Long Term Care Residence, Niagara-on-the-Lake	
Lead Inspector Sydney Withers (740735)	**Inspector Digital Signature** Sydney Withers Digitally signed by Sydney Withers Date: 2023.11.20 11:56:36 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 20, 23-26, 30 and November 1-3, 6, 2023.

The following critical incident (CI) intakes were inspected:

- Intake 00001550/ CI# 2618-000008-22 was related to an injury of unknown origin;
- Intake 00012822/ CI# 2618-000014-22 was related to improper care of a resident resulting in injury; and
- Intake 00016858/ CI# 2618-000021-22 was related to prevention of abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

Section two of the Ontario Regulation (O. Reg.) 246/22 defined resident to resident physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
On an identified date, a resident grabbed another resident's mobility aid, leading to a physical altercation. The resident who initiated the altercation pushed the other resident, which led to the resident falling to the floor and sustaining an injury. Director of Care (DOC) acknowledged that the incident met the definition of physical abuse as set out in the O. Reg. 246/22.

Failure to protect the resident from physical abuse by another resident resulted in physical injury to the resident, posing a risk to their health and safety.

Sources: Resident clinical records, interview with DOC. [740735]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, including assessments, were documented.

Rationale and Summary
On an identified date, two staff were providing care while a resident was positioned in a transfer device. During care, the resident became unsteady, prompting the staff to lower them to the ground and resulting in a near miss incident. The following day, the resident began exhibiting pain and was sent to the hospital where a fracture was identified. Documentation of the incident and the nursing assessment

of the resident were not completed until the following day, after the resident began exhibiting pain during their morning care.

The home's policy titled "Electronic Documentation" listed the College of Nurses of Ontario Practice Standard on Documentation as an additional reference, which required nurses to document in a timely manner and complete documentation during or as soon as possible after the care or event. The Associate Director of Care (ADOC) stated that documentation should have been completed the date of the incident to inform the resident's circle of care of the potential for pain or injury during care following the near miss incident.

Failure to document the incident on the shift it occurred resulted in lack of staff awareness of the incident and potential for pain and discomfort when the resident received care during the shifts that followed the incident.

Sources: Investigation notes, Resident clinical record, Policy C-10-05 "Electronic Documentation" (reviewed April 28, 2023), interviews with registered nursing staff and ADOC. [740735]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used a safe positioning technique when assisting a resident with care.

Rationale and Summary
On an identified date, two staff were providing care while a resident was positioned in a transfer device. During care, the resident became unsteady, prompting the staff to lower them to the ground. The following day, the resident began exhibiting pain and was sent to the hospital where a fracture was identified. The resident's plan of care directed staff to provide care while the resident was in bed. The ADOC further acknowledged that when the resident was positioned in the transfer device, they were not in a safe position to receive care, according to their assessed needs.

Failure to use safe positioning techniques when assisting the resident with care resulted in a near miss incident and placed the resident at risk of pain and discomfort during care.

Sources: Investigation notes, resident clinical record, interview with ADOC. [740735]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure a resident received the required post-fall assessments.

In accordance with O. Reg. 246/22 section 11 (1) (b), where the licensee was required to have a procedure in place, the licensee was required to ensure that the procedure was complied with.

Specifically, staff did not complete the head injury routine (HIR) at the required intervals for a resident when they fell and sustained a head injury.

Rationale and Summary
On an identified date, a resident was involved in a physical altercation, which resulted in them falling to the floor. As a result of the fall, the resident sustained a head laceration, was transferred to hospital and required intervention for their head injury. The HIR was initiated and documented shortly after the incident. The ambulance was unable to arrive for approximately five hours.

The home's procedure titled "Head Injury Routine" required staff to assess and document the resident's vital signs and level of consciousness (LOC) hourly, for the first four hours. Following the first HIR assessment, there were no further documented HIR assessments. Registered nursing staff confirmed that the required HIR assessments were not completed and that they were required until the ambulance arrived.

Failure to complete the required assessment following a fall and resulting head injury increased the risk of changes in the resident's vital signs and LOC going undetected.

Sources: Resident clinical record, Procedure E-35 "Head Injury Routine" (reviewed April 28, 2023), interview with registered nursing staff. [740735]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that for a resident who demonstrated responsive behaviours, monitoring of their behaviour using the Dementia Observational System (DOS) assessment tool was fully documented.

Rationale and Summary
A resident's clinical record indicated that the DOS assessment tool was initiated following an incident involving another resident where they demonstrated a responsive behaviour. The DOC acknowledged that monitoring was initiated for the resident as a result of the incident involving the resident and initiation of a new medication following the incident. A review of the resident's clinical record and an interview with registered nursing staff identified a gap in documentation.

Failure to fully complete the DOS assessment tool, including the summary of behavioural monitoring, may have resulted in an incomplete assessment of the resident's responsive behaviours and response to a new medication.

Sources: Resident clinical record, Program "Responsive Behaviour Philosophy" (revised May 2, 2022), DOS Tool, interviews with registered nursing staff and DOC. [740735]