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: February 16, 2024	
Inspection Number: 2024-1347-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.	
Long Term Care Home and City: Northridge, Oakville	
Lead Inspector Brittany Wood (000763)	**Inspector Digital Signature** Brittany Wood Digitally signed by Brittany Wood Date: 2024.02.29 09:47:03 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
January 29-31, 2024, February 1- 2, & 6, 2024.

The following intake(s) were inspected:

- Intake: #00100133/CI #2862-000043-23 related to an with injury.
- Intake: #00104253 complaint related to improper/incompetent treatment of a resident.

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements for Programs

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (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.

The licensee failed to 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.

Rationale and Summary

On an identified date in 2023, two Personal Support Worker's (PSW) was providing care to a resident. The PSW's were repositioning a resident while in bed and the resident hit their head off the bedrail. A PSW reported the incident to a Registered Nurse (RN). RN took a picture of the wound and started to monitor, however the RN did not complete a head injury routine (HIR).

Associate Director of Care (ADOC) confirmed that an HIR was supposed to be completed immediately after the resident hit their head off the bedrail.

Failure to complete a HIR after the resident hit their head lead to a potential risk the

resident safety and wellbeing.

Sources: Resident clinical records, progress notes, interview with staff. **[000763]**

WRITTEN NOTIFICATION: Bed rails

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
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;

The licensee failed to ensure that where bed rails are used 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.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that all staff participate in the implementation of resident safety and must be complied with.

Specifically, staff did not comply with the policy "Bed Rails and Bed Entrapment" effective August 2023 and revised March 2023.

Rationale and Summary
A resident hit their head off a bedrail during care. The resident had a bed rail assessment last completed in 2022. RN identified that bed rail assessments are to

be completed quarterly and to be documented in the Minimum Data Set (MDS) in their online documentation platform in PointClickCare (PCC).

According to the home's policy titled "Bed Rails and Bed Entrapment" revised August 2023, stated, a determination of the continued need for the bed rail will be evaluated quarterly by the Interdisciplinary Care Team.

Failure to complete the bedrail assessment for the resident lead to increased risk to the resident's safety.

Sources: Policy titled "Bed Rails and Bed Entrapment" revised August 2023, a resident clinical records and interview with staff. **[000763]**