Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Mar 8, 2019	2019_717531_0003	031746-18, 032110-18, 033306-18, 000760-19	Critical Incident System

Licensee/Titulaire de permis

Belcrest Nursing Homes Limited
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

Belmont Long Term Care Facility
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

SUSAN DONNAN (531)

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): February 11, 12, 13, 14, 21 and 22, 2019.

Log #031746-18 Critical incident #2901-000033-19 related to alleged sexual abuse
Log #032110-18 Critical incident #2901-000035-18 related to fall prevention
Log #033306-18 Critical incident #2901-000036-18 related to alleged verbal abuse
Log #000760-18 Critical incident #2901-000001-19 related to fall prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the RAI Coordinator (RAI-C), Personal Care Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a Restorative Aide (RA), resident Substitute Decision Makers (SDM), the Food Services Supervisor (FSS) and residents.

During the course of the inspection, the inspector conducted a tour of the resident home areas, reviewed resident health care records, observed resident care and services, reviewed bed system evaluation records, the fall prevention policy and procedures and the abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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 :

1. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided as specified in the plan.

Critical incident #2901-000035-18 was submitted to the Director on a specified date, which indicated that resident #001 had fallen, the resident's head was on the floor and their leg was caught in the bed rail. The resident sustained superficial injuries .

Review of resident #001's plan of care indicated that the resident's fall prevention interventions included two half rails and that the resident was to be checked on every hour.

PSW #102 during an interview with inspector #531 on February 12, 2019, the PSW told inspector #531, that resident #001's plan of care included hourly checks for resident safety. The PSW stated, that on the specified date they checked on resident #001 at the beginning of their shift at 0610 hours, and then at 0800 hours when they found resident #001 with their head on the floor and their leg was caught in the bed rail. PSW #102 further indicated that their co-worker checked on resident #001 at approximately 0640 hours.

In a separate interview with PSW #115, the PSW stated that they checked on resident #001 at 0640 hours, as they were passing the resident's room at that time, the resident was asleep in bed.

During an interview with the DOC, review of the CIS report and internal documentation, the DOC indicated that resident #001 was checked at 0510 hours, 0610 hours, 0645 hours and then again at 0800 hours. The DOC further indicated that care was not provided to resident #001 as specified in the plan, as the resident was not checked on between 0700 hours and 0800 hours.

The care set out in resident #001's plan of care was not provided as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(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 :

1. The licensee has failed to ensure that where bed rails are used, the resident is assessed and their bed system is evaluated and steps are taken to prevent resident entrapment, taking in to consideration all potential zones of entrapment.

On August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long Term Care Home Administrators about the risk of bed related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are a potential entrapment areas (Zone 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4)

The HC guidance document includes the titles of two additional companion documents. The companion documents referred to in the HC guidance document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance documents outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the information of an interdisciplinary team, individualized resident assessments including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to residents:

Critical Incident #2901-000035-18 was submitted to the Director on a specified date which read, that resident #001 had sustained a fall; the resident's head was on the floor and their leg was caught in the bed rail. The resident sustained superficial injuries .

Review of resident #001's plan of care indicated that two 48 cm bed rails were attached to the center of the bed system which the resident used when being positioned by staff.

During an interview with the RAI-C #118 on February 22, 2019 and the bed system assessment and evaluation team lead; RAI-C #118 indicated that where bed rails are used the resident is assessed and their bed system is evaluated quarterly in accordance with evidence based practices, to minimize the risk to residents.
Review of resident #001's assessment and bed system evaluation for a specified date, with inspector #531, the bed system evaluation, identified an opening between the top of the mattress to the bottom of the rail, between the rail and supports, that the opening posed a potential entrapment risk.

Health Canada's Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" identified the space as "zone 2" for potential entrapment.

RAI-C #118 told inspector #531 that the team assessed the resident and agreed that the

rails were contraindicated, as the resident no longer used them when being positioned and that steps taken to prevent the resident entrapment would include the removal of the rails. The RAI-C #118 indicated that steps were not taken at that time to prevent resident entrapment.

RAI-C #118 indicated that after the incident, the home took immediate action, removed the bed rails and implemented alternative interventions that did not pose a potential entrapment risk.

The licensee failed to ensure steps were taken to prevent resident entrapment risks. [s. 15. (1) (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 steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

Issued on this 12th day of March, 2019

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

Original report signed by the inspector.