Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2021	2021_569508_0008	017238-20, 018246-20, 021386-20, 021869-20, 022000-20, 002350-21, 003947-21, 006339-21	Critical Incident System

Licensee/Titulaire de permis

DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.
161 Bay Street, Suite 2100 TD Canada Trust Tower Toronto ON M5J 2S1

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

Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 Niagara On The Lake ON L0S 1J0

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

ROSEANNE WESTERN (508)

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): April 15 - May 6, 2021.

The following Critical Incidents (CI) were inspected:
- Log #017238-20, related to responsive behaviours;
- Log #006339-21, related to an allegation of abuse;
- Log #(s) 003947-21, 002350-21, 021869-20, 021386-20, 022000-20 and 018246-20, related to fall prevention and management.

Complaint inspection #2021_569508_0007 was conducted concurrently during this CI inspection. Please note: A finding of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (11)(b), related to different approaches not considered in the revision of the plan of care was identified in this inspection and was issued in complaint inspection report #2021_569508_0007.

During the course of the inspection, the inspector toured the facility, observed residents, the provision of care, reviewed resident clinical records, relevant policies and procedures and conducted an Infection Prevention and Control (IPAC) assessment.

During the course of the inspection, the inspector(s) spoke with the Administrators, the Director of Care (DOC), the Assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSW), residents and family members.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 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 when bed rails were used, residents were assessed and their bed system was evaluated in accordance with evidence-based practices to minimize the risk to the resident.

A companion guide titled Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003 (developed by the US Food and Drug Administration) provides the necessary guidance in establishing a clinical assessment where bed rails are used.

The Clinical Guidance document includes high risk hazards associated with the use of bed rails, further monitoring required such as the specific hazards that would need to be monitored while the resident is in bed (with one or more bed rails applied), who would monitor the resident, for how long and at what frequency, how to mitigate the specific hazards and what alternatives to bed rails were available and trialled before the application of bed rails.

Once an interdisciplinary team has initially assessed a resident for their ability to use bed rails, and deemed them to be beneficial to the resident, residents need to undergo additional monitoring for safety hazards. Residents need to be monitored for sleep patterns, behaviours and other factors while sleeping in bed over a period of time to establish risk related hazards. The risk-related hazards include but are not limited to strangulation, suffocation, bruising or injury against the bed rail, suspension, entanglement and entrapment.

The licensee's form entitled Lift, Transfer and Bed Safety Assessment used to document the resident's assessed results, did not include questions related to risk factors for an increased risk of injury associated with bed rail use [i.e. confusion, involuntary movements, sleep disorders, behaviours), conclusions about the resident's sleep habits and behaviours over a period of time, the bed rail alternatives that were trialled (date trialled, what was trialled and whether effective or not), a risk over benefit conclusion or the names of the interdisciplinary team that were involved in the assessment. Although the assessment included some risk related questions, the main focus of the assessment was related to why the resident required the bed rails, the resident's preference and whether they could use them.

Furthermore, the home's Bed Safety policy did not include information related to consent, how staff are to conduct the assessment, for how long, what are they looking for when conducting the assessment (safety issues), no direction about alternatives, role of PSW, role of RN, role of physio, role of family in decision making, what to do when entrapment occurs (report to Health Canada) and other considerations.

Review of resident #005 and #006's lift, transfer and bed safety assessments identified that the assessment did not provide questions or information consistent with prevailing practices in respect to bed safety.

The Administrators, DOC and ADOC acknowledged that they had not reviewed the Clinical Guidance document and that corporately, their Bed Safety assessment and Bed Rail policy were not in accordance with prevailing practices to minimize risk to residents.

Sources: review of the bed safety assessments, Clinical Guidance document, discussion with Environmental Consultant #120 (MLTC) and Administrators, DOC and ADOC. [s. 15. (1) (a)]

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 when bed rails are used, residents are assessed and their bed system is evaluated in accordance with evidence-based practices to minimize the risk to the resident, to be implemented voluntarily.

Issued on this 31st day of May, 2021

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

Original report signed by the inspector.