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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 22, 2015	2015_188168_0036	033638-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THE MEADOWS
12 TRANQUILITY AVENUE ANCASTER ON L9G 5C2

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

LISA VINK (168), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 8, 9, 14, 15, 16, 17, 2015.

During this RQI, the following inspections were conducted concurrently:
Critical Incidents:
009543-14 - regarding duty to protect and reports regarding critical incident
023557-15 - residents' bill of rights and transferring and positioning techniques

This inspection was observed by Inspector Kerry Abbott.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Food Service Manager, dietary staff, recreation staff, registered nursing staff, Personal Support Workers (PSW's), staff Development Coordinator, Quality Nurse, Office Manager, scheduling clerk, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical health records, investigative notes, business files, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 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	Legendé 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's procedure Least Restraint, LTC-K-10, which included Appendix B, revised March 2013, provided direction, on the decision tree, for staff to complete the following: a Least Restraint Initial and Quarterly Assessment in Point Click Care (PCC) and a valid Restraint Consent, Revocation or Refusal form signed.

Resident #012 had a seat belt restraint initiated in November 2015. A review of the clinical record did not include a completed Least Restraint Initial Assessment in PCC nor a completed Restraint Consent, Revocation or Refusal form. Interview with registered staff #110, who was working at the time that the restraint order was received, confirmed that he did not complete the Restraint Assessment in PCC nor the required Restraint Consent form. Progress notes identified that the resident's substitute decision maker (SDM) was informed of the implementation of the seat belt restraint; however, did not specify that informed consent was obtained. The registered staff identified plans to have a formalized consent form signed by the SDM at a later date. [s. 8. (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's procedure Resident Non-Abuse (Ontario), LP-C-20-ON, revised date September 2014, identified the following:
A. "Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. It is an offence under the LTCHA to discourage or suppress a mandatory report. The on-line Mandatory Critical Incident System (MCIS) may be used to forward the required request".

According to the progress notes resident #021 was involved in an interaction with a co-resident #022 in December 2013 and resident #023 on two dates in December 2013. The incidents as detailed in the progress notes suggested that there were reasonable grounds to suspect abuse to co-resident #022 and co-resident #023. Interview with the Administrator confirmed that the incidents were not reported to the Director as required. [s. 20. (1)]

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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the equipment or devices used for the personal support services program were appropriate for the resident based on the resident's condition.

Resident #019 was assessed in February 2014 and identified to require a floor or ceiling lift for all transfers with two staff present. During an internal investigation the home identified that in February 2014, ten days after the lift and transfer assessment, staff did not use a floor or ceiling lift to transfer the resident but rather a sit to stand lift. Interview with personal support workers #105 and #111 verified that a sit to stand lift was used and not a floor or ceiling lift as was the assessed need for the resident at the time of the transfer. The equipment used to transfer the resident was not based on the resident's condition. [s. 30. (1) 2.]

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 the equipment or devices used for the personal support services program are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

Resident #016's plan of care had an identified goal for them to be engaged in one to one leisure activities, through to the next review, of one to two times weekly. This goal statement was also in place during the August 2015, care review. A review of the resident's activity participation report for the months of August, September, October and November 2015, noted that they attended a total of four programs during the identified time period and not one to two a week as desired. The interventions in the plan of care were not effective in meeting the planned goal. Interview of recreation staff #108 confirmed that based on the participation reports the resident did not meet the targeted goal and that the plan of care was not revised when this goal was not achieved. Interview with the resident's SDM identified no concerns with the resident's activity participation, as they had frequent visits from family. [s. 6. (10) (c)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.