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

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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
Sep 23, 2021	2021_848748_0010	010322-21, 012850-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

EMMY HARTMANN (748), PARMINDER GHUMAN (706988)

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): September 8, 9, 10, 13, 15, and 16, 2021. September 15, 2021 was conducted off-site.

The following intakes were completed during this Critical Incident Inspection:

Log #012850-21 was related to an allegation of improper care of a resident resulting in injury.
Log #10322-21 was related to a fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with residents, the Executive Director, Director of Care (DOC), Physiotherapist (PT), Environmental Services Manager, Housekeepers, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents. The inspector also completed an A2 Infection Prevention and Control Program (IPAC) Checklist and a Safe and Secure Inspection Protocol to inspect upon cooling requirements.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that there was a written plan of care for a resident's fall risk that set out the planned care, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident.

A resident was placed at high risk for falls after they had a fall where they sustained an injury.

The resident fell again on five days later, and was subsequently sent to hospital after they presented with a change in condition. The resident passed away in the hospital.

PSW #108 and RN #105 identified that the resident was high risk for falls and they had several interventions in place related to falls.

However, in review of the care plan, there was no written plan of care related to the resident's falls risk that outlined the planned care, the goals, and clear directions to staff.

The DOC verified that there was no written plan of care for the resident's fall risk.

There was risk related to this non-compliance as the lack of a written plan of care placed the resident at risk of not getting the care, and assistance they required.

Sources: A resident's progress notes, assessments, care plan, interviews with PSW #108, RN #105, and DOC. [s. 6. (1)]

2. The licensee failed to ensure that a resident received two staff assistance for an activity of daily living, as set out in the plan of care.

A PSW provided care to a resident. The resident presented with a change in condition after the care was done, and an injury was later identified through diagnostic testing.

The ED confirmed that the care was done by one PSW, contrary to the resident's care plan which stated that the resident required two staff.

Sources: The ED's investigative notes; a resident's care plan; and interviews with a resident, Physiotherapist and ED. [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 there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident; and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of September, 2021

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

Original report signed by the inspector.