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: May 9, 2023	
Inspection Number: 2023-1329-0003	
Inspection Type: Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: The Meadows, Ancaster	
Lead Inspector Pauline Waldon (741071)	**Inspector Digital Signature** Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.05.09 15:26:01 -04'00'
Additional Inspector(s) Farah Khan (695) was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25 - 28, and May 3, 4, 2023

The following intake(s) were inspected:

- Intake: #00003671 - CIS: 2844-000020-22 - Fall resulting in injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan. Specifically, the licensee has failed to ensure that the resident's call bell was within reach.

Rationale and Summary:
A resident was observed in their room and their call bell was not within reach. On the next day the call bell was observed to be in the same position as the previous day.

A staff member stated that the resident uses the call bell when they need assistance and that the call bell was not within reach in the position in which it was observed.

The Director of Care (DOC) reported that having the call bell within reach is a universal falls prevention strategy used in the home for all residents and they want the call bell to be within reach.

When the call bell was not placed within reach, there was a risk that the resident would not be able to request assistance when they needed it.

Sources: Observations, resident's care plan, interviews with staff.

[741071]

WRITTEN NOTIFICATION: Plan of Care: Reassessment, Revision

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that when a resident's care needs changed, that the resident's plan of care was updated.

Rationale and Summary:
A resident had a fall, and they were reassessed whereby their risk for falls changed. The resident's plan of care was not updated to indicate this change in their falls risk.

The resident sustained additional falls over the next 19 days, the last of which resulted in an injury.

The Clinical Lead reported that the expectation was for staff to update the resident's care plan if their

falls risk changes. The DOC verified the resident's care plan was not updated to reflect the change in the resident's falls risk during this time period.

Not updating the resident's plan of care when their falls risk changed may have meant that all front-line staff were not aware of the change, which may have contributed to the resident's subsequent falls.

Sources: Resident's care plan, progress notes, assessments and interviews with the Clinical Lead and DOC.

[741071]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary:
A resident sustained a fall, and there was no post-fall assessment completed. The Clinical Lead reported that a Post Fall Assessment was to be completed for all falls and should have been completed for the resident's fall.

By not completing the Post Fall Assessment, injuries sustained because of the fall, causative factors, and strategies to prevent further falls, may not have been identified.

Sources: Resident's progress notes, assessments, and interview with the Clinical Lead.

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