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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 31, 2023

Inspection Number: 2023-1329-0004

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	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.08.01 14:00:50 -04'00'

Additional Inspector(s)
Erin Denton-O'Neill (740861)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 18 - 21, 24 - 27, 2023

The following intake(s) were inspected:

- Intake: #00008316 - CI: 2844-000023-22 - Related to improper/incompetent treatment.
- Intake: #00016798 - CI: 2844-000029-22 - Related to an unexpected death.
- Intake: #00089788 - CI: 2844-000017-23 - Related to an injury of unknown cause.
- Intake: #00090350 - CI: 2844-000018-23 - Related to falls prevention and management.

The following intake was completed in this inspection:

- Intake: #00086481 - CI: 2844-000010-23 - Related to falls prevention and management.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Rights - Restraints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 24.

The licensee failed to ensure that the following right of residents was fully respected and promoted: every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

Rationale and Summary:
Critical Incident Report (CI) 2844-000023-22 and the home's internal investigation notes identified that two residents were restrained when their plan of care did not include the use of restraints.

By restraining the residents, the residents' right to not be restrained was not respected.

Sources: Residents' plans of care, the home's internal investigation notes, CI 2844-000023-22, interviews with the Executive Director and staff, and Least Restraints policy CARE10-010-01.

[740861]