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
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: November 15, 2024
Original Report Issue Date: October 17, 2024
Inspection Number: 2024-1540-0005 (A1)
Inspection Type: Critical Incident Follow up
Licensee: The Regional Municipality of Niagara
Long Term Care Home and City: The Meadows of Dorchester, Niagara Falls

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change written notification #002 to correct the legislative reference within the rationale and summary.
Change written notification #004 to correct the wording within the rationale and summary.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3-4, and 7-10, 2024.

The following intake(s) were inspected:

- Intake: #00121512 (CIS: M515-000015-24) related to abuse and neglect; and
- Intake: #00125182 (CIS: M515-000019-24) related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1540-0003 related to O. Reg. 246/22, s. 123 (1).

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,

(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that plan of care was updated when the resident's care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary
A resident's plan of care included an intervention for staff to monitor the resident due to a physical altercation with another resident.

The intervention was in place for four months. The Associate Director of Care (ADRC) confirmed the plan of care was not reviewed and revised when monitoring was no longer necessary. The intervention was discontinued during the inspection.

When the plan of care was not updated when the resident's care needs changed, there was a risk that the residents' care needs were not assessed.

Sources: Interview with ADRC; review of resident's clinical record.

Date Remedy Implemented: October 9, 2024

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
On an identified date, a resident had an altercation with a co-resident who entered their room. The co-resident was found in the resident's room and sustained an injury.

A staff and the ADRC acknowledged that when the resident used physical force that resulted in injury to the co=resident, this met the definition of physical abuse.

There was a risk to the resident's safety when they sustained injuries after an interaction with another resident.

Sources: Both resident's plan of care; Critical Incident (CI) Report #M515-000015-24; interviews with staff and the ADRC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an incident of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary
On an identified date, a resident had an altercation with a co-resident who entered their room. The co-resident was found in the resident's room and sustained an injury.

A CI (Critical Incident) Report was submitted by the home one day following the altercation. The report indicated the Ministry of Long-Term Care (MLTC) after-hours pager was not contacted about the incident.

The home's Abuse and Neglect- Zero Tolerance policy last reviewed December 18, 2023 indicated the Administrator, Director of Resident Care, or Charge Nurse will notify the MLTC via phone according to timelines indicated in the Mandatory Reporting and CI Reporting Requirements policy. The policies procedures indicated staff report immediately, if outside of business hours, by calling the Service Ontario After-Hours line.

The ADRC acknowledged the after-hours pager was not called after the incident occurred.

Sources: CI Report #M515-000015-24; Abuse and Neglect- Zero Tolerance policy last reviewed December 18, 2023; Mandatory Reporting and Critical Incidents Reporting Requirements policy last reviewed August 7, 2024; resident's plan of care; interview with ADRC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that the falls prevention and management program provided strategies for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that there is a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

A) When a resident was assessed using a comprehensive validated tool, interventions including need for increased monitoring were not determined and implemented.

Rationale and Summary
On an identified date, a resident had an unwitnessed fall and they were transferred to hospital where they required surgical intervention.

The resident was identified as a risk for falls from an assessment completed one month prior. The resident had several falls between April and August 2024.

The home Falls Prevention and Management policy, last revised April 3, 2024,

stated that residents at risk of falls would be assessed using a comprehensive validated tool, and interventions including the need for increased monitoring would be determined. Intentional Hourly Monitoring was an intervention for falls risk reduction that included increased monitoring and was applied to all residents regardless of fall risk. Intentional Hourly Monitoring required purposeful checking of each resident every hour for pain, positioning needs, and toileting needs. Staff were required to assess the personal environment of the resident to ensure they were safe and remove any potential hazards.

The resident's record indicated that staff were not completing intentional hourly rounding when the resident was identified as a risk for falls. A Personal Support Worker (PSW) and the ADRC confirmed that the resident was not initiated on intentional hourly rounding when they were identified as a risk for falls. The ADRC stated the resident should have been implemented on intentional hourly rounding when the resident was deemed a risk of falls.

When the resident was not initiated on hourly intentional monitoring, there was actual risk to the resident, as there was no strategy in place to reduce the frequency and severity of injuries from falls and maintain the resident's optimal functional level and quality of life.

Sources: Interview with PSW and ADRC; review of resident's clinical record, home's Falls Prevention and Management policy, last revised April 3, 2024.

B) When a resident sustained an unwitnessed fall, the requirement of the program to complete the head injury routine (HIR) was not completed.

Rationale and Summary
On an identified date, a resident had an unwitnessed fall. The home's policy

titled: Head Injury Routine (HIR) & Neurological Assessment, last revised on August 19, 2024, indicated that staff were to complete an assessment for any unwitnessed fall where the resident had a cognitive impairment. The Head Injury Routine (HIR) assessment was to be completed immediately post fall to determine the resident's neurological level. The HIR assessment was comprised of vitals signs, a neurological assessment and the Glasgow Coma Scale.

A Registered Practical Nurse (RPN) and the ADRC confirmed the HIR was not completed when the resident had an unwitnessed fall.

The home initiated the head injury routine assessment when the resident returned from hospital.

When the head injury routine assessment was not completed immediately after an unwitnessed fall, there was a risk that the resident was not monitored appropriately.

Sources: Interview with RPN, ADRC; review of resident's clinical record, policy titled: Head Injury Routine (HIR) & Neurological Assessment, last revised on August 19, 2024.