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

Public Report

Report Issue Date: December 2, 2024

Inspection Number: 2024-1540-0006

Inspection Type:
Proactive Compliance Inspection

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: The Meadows of Dorchester, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6 - 8, 12 - 14, 18 - 22, and 25 - 27, 2024.

The following intake(s) were inspected:

- Intake: #00130956 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain Management

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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care is based on the preferences of a resident.

Rationale and Summary
A resident's plan of care indicated their preference for personal care. Review of the resident's clinical record indicated that they were not receiving their preferred method of personal care for a specified period of time.

A staff stated the resident had communicated their preferences for personal care and confirmed they received the same. The staff acknowledged the resident's preference should be correctly documented in their plan of care.

During the inspection, the resident's plan of care was updated to reflect their

preference.

Sources: Resident's clinical records; interviews with the resident and staff.

Date Remedy Implemented: November 8, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

Specifically, the home failed to post signage throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual in accordance with IPAC Standard, Additional Requirement 11.6 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

Rationale and Summary
Initial observations and a tour of the home with the IPAC lead confirmed that required signage was posted at the home's entrance only.

On November 26, 2024, IPAC Lead confirmed the required signage was posted in the home's foyer and all resident home areas. Observations of the home areas confirmed the same.

Sources: Observations; Interview with the IPAC lead.

Date Remedy Implemented: November 26, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home under section 85 of the Act as required.

Rationale and Summary
During the tour of the home on November 6, 2024, an inspector observed the current version of the visitor policy was not posted as per requirements.

The Administrator confirmed the policy was not posted.

On the same day, the Administrator advised the inspector that the current version of the visitor policy had been posted and available in the front entrance as required. Inspector conducted observation which confirmed the current version of the visitor policy was posted.

Sources: Observation of the home for mandatory postings; Interview with the Administrator.

Date Remedy Implemented: November 6, 2024

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that staff followed the home's policy related to care for residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that Personal Support Worker (PSW) staff report to registered staff if a resident has refused care at least two times and must be complied with.

Specifically, staff did not comply with the policy "Nursing and Personal Support Services", dated May 2024, which was included in the licensee's Nursing and Personal Support Services program.

Rationale and Summary
A resident's care task indicated they refused care on several occasions. A review of the resident's progress notes did not show documentation that the resident refused care or that the substitute decision maker (SDM) was notified about the refusal of care.

The home's Nursing and Personal Support Services policy indicated that PSW staff

are to report to registered staff when a resident has refused care at least two times and registered staff are required to follow-up with the SDM.

A registered staff acknowledged they worked when the resident refused care and were not informed by PSW staff. They stated they would not have been able to notify the SDM because they were not informed. The Administrator confirmed that PSW staff are required to report to registered staff when a resident refuses care at least two times.

There was potential risk that the resident would not receive care when staff did not report that the resident was refusing to registered staff.

Sources: Resident 's clinical records; Nursing and Personal Support Services policy last revised May 2024; interview with staff and the administrator.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection when they exhibited a wound to their right shin.

Rationale and Summary
A resident was receiving weekly wound assessments for an affected area. A staff documented that while completing a dressing change to the affected area, they identified a dressing applied to another affected area.

A review of the resident's clinical records did not indicate documentation related to a secondary wound.

A staff member stated they completed the assessment of resident's affected area and did not identify another affected area. The resident stated that another staff member applied a dressing to the secondary affected area.

The home's Skin and Wound Program Part 3: Skin and Wound Documentation Procedures stated that PSW staff are required to notify registered staff when altered skin integrity is observed in a resident. Registered staff are required to initiate skin and wound assessments. The staff confirmed that when altered skin integrity is noted on a resident, they are to notify registered staff.

When the resident's altered skin integrity was not reported to registered staff, the resident was at potential risk for not receiving immediate treatment and interventions to manage the wound.

Sources: Resident's clinical records; Skin and Wound Program Part 3: Skin and Wound Documentation Procedures policy last revised July 2023; interviews with resident and staff.

WRITTEN NOTIFICATION: Menu Planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)

Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,
(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population.

The licensee has failed to ensure that, prior to being in effect, the Fall/Winter 2024 menu cycle was approved for nutritional adequacy by a registered dietitian (RD) who is a member of the staff of the home.

Rationale and Summary
The home's Nutrition and Environmental Manager confirmed the menu for Fall/Winter 2024 was in effect from November 2024, until May 2025.

The home's policy titled Menu Planning and Approval, last revised May 2022, stated the RD was to review the menu using the menu approval tool and sign and submit the report to the Nutrition Manager prior to implementing the menu.

The RD and the home's Nutrition and Environmental Manager confirmed that the menu cycle evaluation for Fall/Winter 2024 was not completed prior to the menu being served to the residents on a specified date. The RD acknowledged the menu should have been approved prior to being in effect.

When the menu cycle was not approved for nutritional adequacy by a registered dietitian prior to being served to residents, there was risk of nutritional inadequacies in the menu.

Sources: Interview with RD and the home's Nutrition and Environmental Manager; review of the home's policy titled Menu Planning and Approval, last revised May

2022.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

Specifically, the home failed to provide support for residents to perform hand hygiene prior to receiving snacks in accordance with IPAC Standard, Additional Requirement 10.4 under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022; last revised September 2023.

Rationale and Summary
During an observation of the snack service, a staff was observed providing snacks to four residents seated in the lounge. The staff member was not observed to provide support for residents to perform hand hygiene prior to receiving snacks.

The home's Hand hygiene policy, last revised April 2024, directed all staff members to encourage or provide residents with assistance in performing hand hygiene before snacks.

The staff stated they were not aware of the requirement to provide support for

residents to perform hand hygiene prior to receiving snacks. The staff indicated an alcohol-based hand rub (ABHR) pump was set up on the cart they used to deliver the snacks in order to assist the residents with cleaning their hands. The staff acknowledged they should have used the ABHR on the cart. The IPAC Lead acknowledged that staff were expected to support residents with hand hygiene prior to the snack service.

Failure for staff to support residents with hand hygiene prior to the snack service posed a risk of infectious disease transmission.

Sources: Observations; IPAC Standard (revised September 2023), "Hand Hygiene Program", last revised April 2024; Interview with staff and IPAC Lead.

WRITTEN NOTIFICATION: Medication Management System

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that written policies and protocols for the disposal of all drugs in the home were implemented.

Rationale and Summary
During an interview with a registered staff regarding the destruction and disposal of all drugs in the home, they stated that they did not discard wasted denatured narcotic medication in the medication disposal container. The staff stated they had access to the written policy and were not aware that the policy directed staff to

place denatured wasted medication into the medication disposal container.

The policy Destruction and Disposal of Narcotic and Controlled Medications, revised June 2023, directed staff to denature wasted medication and place into the medication disposal container. The Director of Care (DOC) confirmed that the staff were to denature wasted medication and place into the medication disposal container.

Failure to not implement the policy for disposal of medications resulted in improper medication disposal practices.

Sources: Interview with staff and DOC; policy "Destruction and Disposal of Narcotic and Controlled Medications", revised June 2023.

WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident.

The licensee has failed to ensure that no resident administers a drug to themselves unless the administration has been approved by the prescriber in consultation with the resident.

Rationale and Summary
During observations of a Resident Home Area, a registered staff entered a resident's room and notified the resident that their medication was in a medication cup. The

staff placed the medication cup on a desk in the resident's room and left the room.

Inspector spoke with the resident in a separate interview. The resident stated they do not administer medications to themselves, and staff always supervised medication administration. The registered staff stated they should have administered the medication to the resident as per their plan of care. The registered staff reviewed the resident's plan of care and indicated that the resident was not to administer drugs to themselves.

The DOC indicated the expectation in the home was for no resident to administer a drug to themselves unless the administration had been approved by the prescriber.

When the resident was provided a drug to administer to themselves without approval by the prescriber in consultation with the resident, the resident was placed at risk of inappropriate usage of the medication.

Sources: Observations; Interviews with resident, staff and DOC; Record review of resident's plan of care.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,

ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the Continuous Quality Improvement (CQI) report required under Ontario Regulation 246/22 s. 168 (1) included a written record of all the required information.

Rationale and Summary
A review of the home's website included their 2023 CQI report. Review of the 2023 CQI report revealed that not all the above-mentioned required information, was included in the report. The Administrator, the home's designated lead for the home's CQI initiative, acknowledged the required information was not included in the CQI report.

There was minimal risk to residents when the licensee failed to ensure that the above-mentioned information was included in the CQI report.

Sources: Review of the CQI report for 2023; interview with Administrator.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to ensure the CQI report required under Ontario Regulation 246/22 s. 168 (1) included a written record of all the required information.

Rationale and Summary
A review of the home's website included their 2023 CQI report. Review of the 2023 CQI report revealed that not all the above-mentioned required information, was included in the report. The Administrator, the home's designated lead for the home's CQI initiative, acknowledged the required information was not included in the CQI report.

There was minimal risk to residents when the licensee failed to ensure that the above-mentioned information was included in the CQI report.

Sources: Review of the CQI report for 2023; interview with Administrator.