Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
September 23, 2010	2010-120-2841-01OCT124320	H-01292 – Critical Incident

Licensee/Titulaire

Revera Long Term Care Inc., 55 Standish Court, Mississuaga, ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

The Meadows LTC Centre, 12 Tranquility Ave., Ancaster, ON L9G 5C2

Name of Inspector(s)/Nom de l'inspecteur(s)

Bernadette Susnik, LTC Homes Inspector – Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct an inspection following the receipt of a Critical Incident #2844-000015-10 related to a falling accident.

During the course of the inspection, the above noted inspector spoke with the Director of Care, Administrator, the RAI-MDS Co-ordinator, a PSW and a Physiotherapist.

During the course of the inspection, the inspector reviewed documentation, examined several bed alarms and reviewed various resident bedrooms.

The following Inspection Protocols were used during this inspection:

- *Accommodation Services – Maintenance*
- *Falls Prevention*

There are findings of Non-Compliance as a result of this inspection. The following action was taken:

1 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: ***The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s. 6(9)3.*** The licensee shall ensure that the following are documented:

3. The effectiveness of the plan of care.

Findings:

A resident's plan of care indicated that they were assessed as having a high risk for falls and would therefore benefit from the following strategies which were initiated to reduce their risk of falls;

- A range of motion and balance exercises were implemented for the resident during the month of May 2010. The range of motion exercises was not supervised by any of the qualified staff members of the home. The resident's private caregiver was given the task of offering and supervising these exercises. The balance training was implemented by the physiotherapist and documentation with respect to this intervention indicated that the resident missed 2 training sessions out of the 5 that they were to receive in May.

- A restorative walking program, another intervention, was to include walking 4 to 5 times per week. The physiotherapist indicated that the "walking" intervention consisted of assisting the resident to walk once per day between their room and the dining room. Between the months of June 1st and August 31st, 2010, documentation made by the home's physiotherapist indicated that the resident was assisted to and from the dining room only 12 times, instead of the required 48 times.

No documentation or assessment was made to indicate whether the above noted strategies to mitigate the resident's risk of falls was effective.

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 with s. 6(9)3. in respect to ensuring that the effectiveness of the plan of care is documented, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** B. Smith Mar 31/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).