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: August 29,2023	
Inspection Number: 2023-1540-0004	
Inspection Type: Complaint Critical Incident	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: The Meadows of Dorchester, Niagara Falls	
Lead Inspector Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2023.09.22 09:09:03 -04'00'
Additional Inspector(s) Brittany Wood (000763)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 9, 10, 11, 14, 15, 2023.

The following intake(s) were inspected:

- Intake: #00018129 - Critical Incident(CI) # M515-000004-23 related to Prevention of Abuse and Neglect.
- Intake: #00092773 - Complaint 245-2023-1843 related to Resident Care and Support Services and Safe and Secure Home.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

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 (1) (a)

The licensee has failed to ensure that there is a written plan of care for resident that sets out the planned care for the resident.

Rationale and Summary
Resident's Substitute Decision Maker (SDM), was coming in daily and providing personal care to the resident . Resident's plan of care did not reflect this information. Assistant Director of Care (ADOC) acknowledged the plan of care should have been updated to reflect the care needs of resident.

Failure to ensure resident's written plan of care set out the planned care for the resident had the potential for staff to not be informed on the personal care needs of the resident.

Sources: Resident's clinical record, the home's investigation notes and interview with ADOC. [000763]

WRITTEN NOTIFICATION: Plan of care

NC #002 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 the plan of care for resident was provided to the resident as specified in the plan.

Rationale and Summary
Resident's plan of care indicated for a yellow wander strip to be present across the resident's doorway for safety and security in their environment. On a day in August 2023, resident was observed to be sleeping in their bed in their room, and staff did not put up the yellow wander strip across the doorway.

Personal Support Worker (PSW) and Registered Nurse (RN) acknowledged that the yellow wander strip was to be across resident's doorway when the resident is in their room and that staff did not put it up across the doorway at that time.

Failure to ensure that the care set out in the plan of care regarding resident's yellow wander strip led to increased risk to the resident's safety.

Sources: Resident's clinical record, observations and interviews with staff.
[000763]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee has failed to ensure resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required.

Rationale and Summary
On a day in August 2023, resident was observed in their bed throughout the hours of 1249 and 1449. Resident's plan of care indicated to maintain intact skin integrity, they were to be repositioned every two hours. Personal Support Worker (PSW) and ADOC acknowledged that resident should have been repositioned during that time, but the repositioning did not happen.

Failure to ensure resident was repositioned every two hours put the resident at higher risk of injury of pressure ulcers.

Sources: Observations, resident's clinical records, interviews with staff.
[000763]