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: January 24, 2024
Inspection Number: 2023-1540-0006
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	**Inspector Digital Signature**
Cathy Fediash (214)	Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2024.01.26 11:22:14 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-11, and 15-17, 2024.

The following intake(s) were inspected:

- Intake: #00099371-Complaint related to prevention of abuse and neglect, and resident care and services.
- Intake: #00102103-Critical Incident (CI) #M515-000040-23 related to falls prevention and management.
- Intake: #00103706-CI #M515-000043-23 related to Improper/Incompetent treatment.

The following intake was completed in this inspection:

- Intake: #00098484- CI #M515-000035-23 related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and 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 (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; or when reassessment, revision is required.

The licensee failed to ensure that a resident's plan of care was reviewed and revised

to include a transfer intervention.

Rationale and Summary

During care, a resident sustained an injury.

The home's investigative notes and an interview with the Director of Resident Care (DRC) confirmed that an intervention had been implemented four days later.

The care plan was reviewed, and the intervention had not been listed.

The DRC indicated when they implemented the intervention, it had been documented in a different area of the residents plan of care and should have also been documented in the electronic care plan as this is the area that staff refer to identify the needs and preferences of the resident.

Remedy taken before conclusion of the inspection:

During this inspection, the resident's electronic care plan was updated to include the intervention.

Sources: a resident's plan of care including progress notes and care plan, home's investigative notes and an interview with the DRC.

Date Remedy Implemented: January 11, 2024. [214]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's written plan of care set out clear directions to staff and others who provided direct care in relation to providing an activity of daily living (ADL).

Rationale and Summary

During care, a resident sustained an injury.

The resident's care plan for a specified ADL contained an intervention that had been created at least nine months prior to the date they sustained an injury.

This intervention was in relation to positioning; however, no further directions were provided that specified the position; how to achieve the position; how many staff were required to be perform the intervention and at what point of care, the intervention could be stopped.

Interviews with managers and PSW staff confirmed the intervention was not clear and PSW staff indicated they would not know how to provide this intervention.

When directions are not clear to staff and others who provide direct care, there is potential risk for the intended intervention to have not been provided as intended

and has the potential to cause harm to the resident and/or the person providing the direct care.

Sources: resident care plan and progress notes, and interviews with PSW's and other staff. [214]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 a resident's plan of care was based on a pain assessment.

Rationale and Summary

During care, a resident sustained an injury.

A progress note indicated the resident had been assessed for pain; however, the note had not identified how they were assessed or the outcome of the assessment.

A specified progress note assessment indicated the resident had no pain.

A different progress note assessment identified a specified pain assessment score

of zero (0).

The licensee's pain management program policy identified a specified pain progress note assessment, and for this resident, a specified pain scale, to have been conducted.

Review of the resident's clinical record indicated no pain assessments had been completed.

Interviews with managers and registered staff, confirmed no pain progress note assessments or pain assessments had been completed in the resident's clinical record to substantiate the documentation of no pain.

When the plan of care is not based on an assessment, this can impact the validity of the plan of care and has the potential to put the resident's needs at risk of not being identified.

Sources: resident's plan of care including progress notes, assessments, Risk Management, the licensee's Pain Management Program Overview policy, (reviewed October 2, 2022), and interviews with registered staff and others. [214]