Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 5, 2016	2015_250511_0015	033657-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD THOROLD ON L2V 4T7

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

THE MEADOWS OF DORCHESTER
6623 Kalar Road NIAGARA FALLS ON L2H 2T3

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

ROBIN MACKIE (511), BARBARA NAYKALYK-HUNT (146), IRENE SCHMIDT (510a), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 3, 4, 8, 9, 10, 11, 14 and 15, 2015

During this inspection the following complaint and critical Incidents were inspected:
009358-14 Complaint, 009695-14 Complaint, 005214-15 Complaint, 017890-15 CIS, 024320-15 CIS, 029127-15 CIS

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Programs Manager, Clinical Documentation and Informatics Coordinator (CDI),Registered Nurses (RN), Registered Practical Nurses (RPN), Scheduling Clerk, Personal Support Workers (PSW), physiotherapy/occupational therapy aid, Dietary staff, housekeeping staff, family members and residents.
During the course of this inspection, the inspectors: toured the home; reviewed meeting minutes and internal investigation notes; reviewed policies and procedures; reviewed resident health records; and observed the provision of resident care and dining services.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During Stage One of the RQI Resident #301 had six of their Minimum Data Set (MDS) Quality Care Life Indicators (QCLI)trigger for further inspection for the period of April 2015-September 2015. A review of the clinical record indicated Resident #301 had a history of multiple disease diagnosis. A nursing progress note in the month of August 2015, indicated a change in the resident's condition when they were diagnosed with a fever and an infection. A short term care plan was updated to reflect the infection. In August, the resident continued with a health decline which included low food and fluid intake. The Registered Dietitian was requested by staff to assess the resident related to the recent decline in their health condition. In the morning, on a day in August 2015, a note was placed in the RN day planner to notify medical doctor and obtain an order for a palliative pathway measure, if needed. The family consented to the palliative pathway and the resident became bed fast with no transfer to hospital. On an evening in August 2015 the Substitute Decision Maker indicated, due to comfort measures, they did not want the PSW's to reposition the resident. A progress note indicated the care plan had been updated to reflect palliative/end of life status. The resident passed away.
A review of the care plan had not indicated the plan was reviewed and revised with the above nursing concerns and interventions when the resident's care needs changed related to being bed fast, altered position and changing, poor fluid intake or when they were placed on a palliative pathway. Interview with the CDI coordinator confirmed the significant change in status assessment was not completed and the plan was not reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one Registered Nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times, except as provided for in the regulations.

The home failed to ensure that a registered nurse was on duty and present in the home on the following dates; all were eight hour night shifts:
November 28, 2014;
December 5, 6, 27, 29, 30, 2014;
February 11, 2015.
This information was confirmed by the home's schedules and the Administrator. [s. 8. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where this regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, b) was complied with.

The Licensee's policy and procedure for Meal Service, Provision of Care, Treatment and Services/Nutritional Care, revised May 15, 2015, # 12 stated " Each resident would receive encouragement,supervision and assistance with food and fluid intake to promote his/her safety, comfort and independence in eating.".
On a specific day, during the RQI, four residents (#304, #305, #015, #017) with cognitive impairment were observed unsupervised for greater than 15 minutes with fluids in the dining room. During this 15 minutes, two residents #304 and #305 were observed to be sharing and drinking from each others cups. According to the residents' plan of care they were both on regular fluids and required limited and minimal assistance with meals. Interview with the Administrator confirmed the expectation, as per the home's policy, would have required the staff to supervise the safe administration of fluids in order to prevent cognitively impaired residents from drinking from other resident cups or fluids not intended for them. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

In June 2015 resident #043 was taken to hospital with an injury that required treatment. The resident returned to the home on a day in July 2015. The Administrator confirmed that the critical incident report regarding this transfer to hospital was submitted 7 days after the return to the home. [s. 107. (3) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer’s instructions.

During the RQI Resident #001 was observed to be self propelling in a wheelchair about the resident home area. The resident had a fastened seat belt that was loose fitting, allowing approximately 5 inches of space between the belt and the resident's abdomen. A review of the resident's clinical record indicated the resident had cognitive impairment and a history of falls. The clinical record indicated they received a medication that may have an increased affect on falls and wore a seat belt restraint daily.
Interview with the RPN, who cared for the resident on the floor, confirmed the seat belt was fitted loose and should be 'snugged' up comfortably to the resident's abdomen. The RPN indicated the staff would use two finger widths to approximate the distance for a safe fit.
On a second day during the RQI, Resident #001 was observed again to be self propelling in a wheelchair about the resident home area. Their seat belt was observed to be secured again but was over top of the tote bag (for wheelchair footrests) that was secured at the back of the wheelchair. The concern was noted that the belt could slip down off the tote and become too loose.
A review of the manufacturer "Pelvic Support Belt", installation and user's instructions indicated the users pelvis needed to be secured to prevent the risk of strangulation from sliding down in the chair. When the belt was properly adjusted the belt should fit snug and have no slack. A safety check was required to ensure that there was no interference with other devices.
Interview with the Administrator and a member of the physiotherapy department confirmed the staff had not applied the physical device in accordance with the manufacturer’s instructions. [s. 110. (1) 1.]

Issued on this 5th day of January, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.