Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 2, 2020	2020_575214_0013	004201-20, 011558-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way 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

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 23, 25, 26, 29, 2020, as both an off-site and on-site inspection.

Please note: The following intakes were completed during this Critical Incident System (CIS) inspection:

-Log #004201-20- related to Falls prevention and management.

-Log #011558-20- related to Falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Clinical Documentation and Informatics (CDI) lead; registered staff; Personal Support Worker (PSW).

During the course of this inspection, the inspector(s) reviewed the Critical Incident System (CIS) report; resident clinical records; home's investigative notes; meeting minutes; policy and procedures and staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident Assessment Protocols for resident #001, were integrated, consistent and complemented each other.

A review of CIS # M515-000005-20 indicated that on a specified date, resident #001 sustained an unwitnessed fall that resulted in an identified injury.

A Minimum Data Set (MDS), significant change in status assessment was conducted on an identified date. A review of corresponding Resident Assessment Protocols (RAPS) indicated under an identified RAP that as a result of this incident, resident #001 had a recent change in health with a specified activity of daily living (ADL) decline. This RAP further indicated resident #001 had no concerns with the same specified ADL.

A review of a second identified RAP and dated the same date, indicated resident #001 recently had a change in health related to this incident with a decline to the same specified ADL.

Both RAPS were completed by staff #105.

During an interview on an identified date, with the Administrator and staff #105, it was indicated that documentation in relation to MDS coding and RAPS was expected to be completed for all residents who exhibited a significant change in status and that resident #001 had experienced a decline in a specified ADL. Staff #105 indicated that when completing the above assessments for resident #001's significant change in status, they forgot to update all aspects of the identified RAP and as a result, the assessments were not integrated, consistent or complemented each other. [s. 6. (4) (a)]

Issued on this 6th day of July, 2020

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

Original report signed by the inspector.