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
Apr 19, 2022	2022_569508_0004	015041-21, 002259-22, 002733-22	Complaint

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 18, 21, 22, 23, 25, 2022.

During this inspection, the following was inspected:

Log # 015041-21 related to continence care and bowel management, neglect and food quality;
Log #:002259-22 related to bowel management;
Log #:002733-22 related to medication administration and responding to complaints;

During the course of this inspection, the inspector toured the home, observed the provision of care, meal service, infection prevention and control (IPAC) practices and reviewed resident clinical records, internal investigative notes, 2021 resident satisfaction survey, food committee meeting minutes, written complaints and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Dietary and Environmental Manager, dietary aides, registered staff, Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

- **3 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 rang for assistance as they needed to use the toilet. The resident's plan of care indicated that the resident was a two person transfer with a mechanical lift for transfers and toileting.

A PSW responded to the call bell and told the resident they would have to wait as they needed a second staff to assist with the transfer; however, another PSW was not available to assist.

The PSW did not attempt to get assistance from other staff that may have been available to assist. The care set out in the plan of care for this resident was not provided as specified in the plan.

Sources: Resident #001's plan of care, internal investigative notes and interviews with PSW #105, resident #001. [s. 6. (7)]

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 to ensure that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person had reasonable grounds to suspect that neglect of a resident by staff had occurred, immediately report the suspicion and the information upon which it was based to the Director.

An allegation of neglect was brought forward to the DRC by a family member of a resident.

The allegation was that staff neglected to provide care to the resident which had a negative outcome to the resident. After the allegation was discussed with the DRC, an investigation was initiated; however, the Director had not been notified of the allegation of neglect.

Sources: Investigative notes, interview with family member and staff #100. [s. 24. (1)]

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 to ensure that when a person has reasonable grounds to suspect that neglect of a resident by staff has occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint made to the licensee concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint.

An email was sent by a resident's family member to staff #100 in 2022 regarding concerns about an identified staff person and a care concern.

The family member indicated that they did not receive an acknowledgement or a response of the email.

Staff #100 reviewed the email and the home's complaint log and confirmed they did not respond to the complainant within 10 business days of receipt of the complaint.

Sources: Email and interviews with family member and staff #100. [s. 101. (1) 1.]

Issued on this 27th day of April, 2022

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

Original report signed by the inspector.