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

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| **Report Issue Date:** July 9, 2024 |
| **Inspection Number:** 2024-1540-0003 |
| **Inspection Type:**<br>Complaint<br>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** |
|---|---|
| Stephanie Smith (740738) | Stephanie D Smith<br>Digitally signed by Stephanie D Smith<br>Date: 2024.07.10 10:18:19 -04'00' |

**Additional Inspector(s)**
Erika Reaman (000764)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12-14, 17-21, and 24-26, 2024

The following intake(s) were inspected:

- Intake: #00113401 - Complaint regarding prevention of abuse and neglect.
- Intake: #00113444 - Critical Incident (CI): M515-000009-24 - Falls prevention and management.
- Intake: #00115831 - CI: M515-000012-24 - Falls prevention and management

The following intake(s) were completed in this inspection:

- Intake: #00109528, CI: M515-000005-24 was related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (1) (a)**
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,
(a) the planned care for the resident;

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

**Rationale and Summary**
During the inspection, a resident was observed several times and at each observation the resident had an intervention in place. Staff indicated that this intervention was applied by direct care staff and that it was used daily. The resident's plan of care did not include this intervention.

On a later date in June 2024, the Director of Resident Care (DRC) updated the resident's plan of care to include this intervention.

**Sources:** Resident's plan of care, observations, interviews with direct care staff and Registered Staff. [740738]

Date Remedy Implemented: June 24, 2024

## 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)**
Plan of care
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.

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

**Rationale and Summary**
On a specified date in June 2024, a resident was being transferred via a mechanical lift. The resident's care plan identified that staff were to ensure that an intervention was in place prior to transferring the resident. During the observation, the intervention was put in place mid-way through the transferring process.

Failure to ensure that the resident's care was provided as specified in their plan of care put the resident at risk of injury.

**Sources:** Resident's care plan, observation, interview with Registered Staff, and DRC. [740738]

## WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care for a resident was documented.

**Rationale and Summary**
A resident had an activity of daily living (ADL) that required staff assistance. April 2024 documentation was reviewed and there were nine shifts missing documentation for the ADL. The DRC stated that the expectation was for direct care staff to complete their documentation by the end of the shift, and that if the ADL did not occur, staff should have documented "not applicable" (N/A).

Failure to ensure that the provision of care for a resident was documented had risk for incorrect/incomplete documentation.

**Sources:** Resident's clinical record, interview with DRC. [740738]

## WRITTEN NOTIFICATION: Resident records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 274 (b)**
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

**Rationale and Summary**
The home used a secure messaging system between Registered Staff and the physicians. A secure conversation with the resident's physician began on a specified date in May 2024. The messaging continued with additional dates in the same conversation which concluded two days later. This secure conversation did not appear in a resident's clinical records until five days after the conversation concluded.

A Registered Staff indicated that secure conversations with physicians were required to be ported to the resident record by Registered Staff or another staff who had access. This step needed to be completed within 14 days in order to ensure the message did not disappear, as messages would expire after 14 days.

Failure to ensure that a resident's clinical records were kept up to date at all times had potential for miscommunication between staff regarding that resident's condition.

**Sources:** Resident's clinical records; interview with Registered Staff. [000764]

## COMPLIANCE ORDER CO #001 Medication management system

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 123 (1)**
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:
a) Educate all Registered Staff on the home's specified policy, with a focus on when to notify the physician or Nurse Practitioner (NP) regarding any change in condition;
b) Complete weekly audits on residents receiving the specified therapy to ensure their assessment has been completed by the physician or NP for a period of one month;
c) Retain records of the education provided, the content of the education, who attended the education, the date it was held, staff signatures indicating they attended, and who provided the education;
d) Retain records of the audits completed for Inspector review.

**Grounds**
The licensee has failed to comply with the Medication management system for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that there is an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy

outcomes for residents and must be complied with.

Specifically, staff did not comply with the policy "High Alert Medications", dated September 10, 2021, which was included in the home's Medication management system.

**Rationale and Summary**
On a specified date in April 2024, a resident had a fall and sustained an injury. The resident was receiving a specified therapy, which placed them at a high risk for a change in condition. The resident died a specified number of days post fall.

The home's policy titled "High Alert Medications" indicated that for residents who received anticoagulant medication, the NP/attending physician would be notified of any signs of a specific change in condition.

The resident had this specific change in condition. This was first observed by staff on a specified date in May 2024. There was no documentation indicating that the NP or attending physician were notified of this.

Two days after that date, the resident was assessed to have another change in their condition. The resident was transferred to the hospital by Registered Staff for further assessment. As per documentation this was the first time that the attending physician was notified of any change in condition. Upon return to the home, the resident continued to experience a change in their condition on a specified date in May 2024, which then continued to the next day. Documentation during that time did not show that the attending physician or NP were notified by any Registered Staff of any of the occurrences of the change in condition between the specified date in May 2024 and the next day in May 2024. As per the home's process, the attending physician was the practitioner to be notified during that time.

The resident had an assessment completed in the home on a specified date in May 2024, which had indicated the assessment results were compromised. The home stamped the assessment results as reviewed on the day after and the stamp indicated that physician was not notified. The resident's attending physician stated that this assessment should have been redone given that the results were compromised. The home's policy titled "High-Alert Medications" indicated a protocol will identify the therapeutic range for the specific resident, frequency of the assessment, and instructions provided by the Physician/NP. The resident's assessment was to be completed weekly as per physician's orders. Due to this assessment being incomplete, the home could not assess the resident's current status and had based their plan of care on an older assessment result.

The resident's death was referred to a coroner. The investigating coroner stated that the ongoing change in condition that the resident experienced was a contributing factor to their death.

The resident's' Substitute Decision Makers (SDMs) reported that the resident continuously experienced the change in condition after their fall. The SDMs indicated that they were not aware if the attending physician came to assess the resident's change in condition. They indicated all their communication was with the NP within the home. There was no documentation to support or deny that the SDMs had notified Registered Staff of their concerns regarding the specified change in condition.

The DRC outlined that the attending physician was notified of the change in condition on a specified date in May 2024, as indicated in the home's secure messaging system, and no other dates were mentioned. The DRC acknowledged that staff did not follow the home's policy for notifying the physician or NP for any incidents of the specified change in condition when receiving a specific therapy,

when there was no notification of the change in condition that occurred for the resident on two specified dates in May 2024.

Failure to follow the home's policy for "High Alert Medications" led to potential harm for the resident.

**Sources:** Resident's clinical records, the home's internal compliance review, the home's policy "High Alert Medications" September 10, 2021, interviews with Registered Staff, NP, investigating coroner, attending physician, DRC and SDMs. [000764]

**This order must be complied with by** August 20, 2024

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following

to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide

instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.