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

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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
Dec 8, 2014	2014_323130_0024	H-001631-14	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

GILLIAN TRACEY (130), CATHY FEDIASH (214), ROSEANNE WESTERN (508)

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): November 24, 25, 26, 27, 28, December 2, 3, 4 and 5, 2014.

Please Note: The following critical incidents were conducted simultaneously with this RQI; H-000441-14, H-000736-14, H-001232-14. The following complaint was conducted simultaneously with this RQI: H-000107-14.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Resident Assessment Instrument Coordinator (RAI), Manager of Dietary Services, Manager of Dietary Services, Registered Dietitian, Registered staff, personal support workers, dietary staff, President of Residents' Council, Acting President Family Council and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
5 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

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 failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A) The written plan of care for resident #104 indicated staff were to ensure that specific safety interventions were in place and in good working order when the resident was in bed and call bell to be within reach of resident at all times. The same plan also indicated to replace these items if they were used by resident and were part of the plan of care. Registered staff interviewed confirmed the written plan of care did not provide clear directions to the staff. (Inspector #130)

B) The written plan of care for resident #105 indicated the resident was at risk for falls and required specific safety interventions when in bed and/or in their wheelchair. The

same plan indicated the resident used a walker for mobility and directed staff to observe ambulation for endurance and steadiness. The plan also indicated the resident was on a turning and repositioning schedule because the resident was no longer aware of the need to be turned and repositioned. Front line and Registered staff confirmed the written plan of care did not provide clear directions to staff in relation to the resident's mobility status. (Inspector #130) [s. 6. (1) (c)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The written plan of care for resident #104 indicated the resident required extensive assistance of one staff for transfers; extensive assistance of two staff for bed mobility and supervision for mobility on the unit. Staff confirmed the resident ambulated on the unit without supervision, transferred self without assistance and was able to turn and reposition independently when in bed. Staff confirmed the written plan was not based on the actual needs of the resident. (Inspector #130) [s. 6. (2)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A) A review of resident #106’s quarterly minimum data set (MDS) completed on a specified date in 2014, indicated under skin condition that the resident was coded as having impaired skin integrity. A review of the pressure ulcers Resident Assessment Protocol (RAP) for this resident indicated that the resident had worse impaired skin integrity than first identified. An interview with the RAI Coordinator confirmed that staff had not collaborated in the assessment of the resident so that the assessments were integrated and were consistent with and complemented each other. (Inspector #214) [s. 6. (4) (a)]

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

A) Resident #103 was identified as a risk for falls. A review of the resident's plan of care that staff refer to for direction, indicated that the resident required a specific safety intervention. It was observed by the Inspector on a specific date that the specific safety intervention was not in place as specified in the plan. This information was confirmed by

staff. (Inspector #508)

B) The written plan of care for resident #105 indicated staff were to ensure that a specific safety device be in place when they were in their chair. On a specified date in 2014, the resident sustained a fall with injury from their chair. The clinical record stated that the safety device was not in working order at the time of the fall. The batteries were replaced and the device was still not working. Staff confirmed the device was not checked and in good working order when the resident was in their chair, as specified in the plan. (Inspector #130) [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 the plan of care sets out clear directions to staff and others who provide direct care to the resident; to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the equipment was maintained in a safe condition and in a good state of repair.

A) It was observed during stage one observations that the call bell in an identified room was not signaling to staff when tested by the Inspector. The home's call bell system included a presence light outside resident's rooms and a nurse call pager which PSW staff would carry. Both the presence light and the pager were unresponsive when the call bell was pushed. The call bell system was tested in six resident rooms including the identified room, and it was identified that three out of the six call bells tested were not functioning. The Administrator confirmed that the resident-staff communication and response system in the identified rooms were not functioning. (Inspector #508) [s. 15. (2) (c)]

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 the equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

A) On an identified date in 2014, resident #300, who had cognitive impairment wandered into the bedroom of co-resident #301. Resident #301 pushed resident #300, which resulted in a fall with injury for resident #300. The DRC confirmed that resident #300 had no prior incidents of aggression during his residency at the home; however, the home was aware of a history of aggression gathered from the pre-admisison records and that resident #300 was injured as a result of the incident.(Inspector #130) [s. 19. (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 all residents were protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) A review of the home’s annual program evaluation for the Skin and Wound Care Program 2013 indicated the date of the evaluation, the names of the persons who participated in the evaluation and a summary of the changes made; however; had not included the date that the changes were implemented. An interview with the Administrator confirmed that the annual program evaluation had not included the date that the changes were implemented.(Inspector #214) [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) A review of resident #108’s written plan of care indicated that staff were to monitor the resident's urinary output and note changes to Registered staff. A review of the Point of Care (POC) documentation from over a two week period in 2014, had included a total of 55 documented entries for the appearance of the urine. Out of these, 33 times there was documentation to indicate an abnormality. Interviews with front line nursing staff indicated that when the above abnormalities were identified, they were reported to registered staff. A review of the resident’s clinical record indicated that no assessment, reassessment, interventions or the resident’s response to interventions had been documented. The RAI Coordinator confirmed that the home’s expectations were to report these abnormalities to the registered staff and that registered staff were to document the reported abnormalities including any assessments, interventions and the resident’s response to the interventions in the residents’ clinical record and that the home had not documented these actions for the above instances.(Inspector #214) [s. 30. (2)]

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 the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented and to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

A) On December 2 and 5, 2014 at 1145 hours, it was observed that dietary staff had placed beverages on the dining tables at least 15 minutes in advance of residents being seated. Residents with cognitive impairment were observed wandering in the dining room without supervision during this time period. Staff interviewed confirmed this was routine practice to place beverages on tables before staff were present in the dining room and supervising residents. Staff confirmed this practice presents opportunities for beverages to be tampered with, which could result in an infection control risk to residents.(Inspector #130) [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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 any plan, policy, protocol, procedure, strategy or system was complied with.

A) It was observed on November 28, 2014, that when the call bell was activated by the Inspector in a specific room, that staff did not respond until approximately 12 minutes after the call bell was activated. It was also observed that the PSW that responded to the call bell was not carrying a pager which alerted staff when call bells were activated. The PSW had only noticed that the call bell was activated from a light which was visible outside the resident's room. The PSW confirmed that they were not carrying a pager because there were only two pagers available that shift and there were three PSW staff. The home's policy # PCS07-005, in the Resident Care and Services manual, titled "Nurse Call Pagers and Presence Lights, Use of, directed all registered staff and PSW's to carry and use nurse call pagers as assigned. Pagers would be turned on by staff upon arrival for scheduled shift, and the alert mode on pager set to audible tone only. Technical problems with pagers must be communicated to the DRC or designate immediately. It was confirmed by the DRC that staff did not report that a pager was missing until after it had been identified by the Inspector. (Inspector #508) [s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident’s plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) A review of resident #106's clinical record indicated that they had impaired skin integrity dating back to 2013. A review of the resident's clinical record indicated that a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, had not been completed at the onset of the affected area. The RAI Coordinator confirmed that this assessment had not been completed.(Inspector #214) [s. 50. (2) (b) (i)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

A) It was observed by the Inspector on November 28, 2014, during meal service on Primrose Place, that the french toast that was being served for lunch had not been covered during distribution, however, the alternative meal choice was. At the end of the meal service, the Inspector requested a piece of the french toast and it was confirmed that the toast was cold. During an interview with the dietary staff, they indicated that she usually had both food trays covered with tin foil during meal service, however, she removed the tin foil on the french toast as it had not been applied correctly. It was confirmed by staff that the french toast had not been covered and that the french toast was cold at the end of meal service. (Inspector #508) [s. 73. (1) 6.]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.