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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Mar 12, 2019	2019_704682_0004	022772-17, 000103-18, 000197-18, 007827-18	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

AILEEN GRABA (682)

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): February 25, 26, 28, March 1, 2019.

The following Critical Incident inspections were conducted:
000197-18 related to falls prevention
007827-18 related to falls prevention
017642-17 related to falls prevention
022772-17 related to falls prevention
000103-18 related to hospitalization and change in condition.

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 (RAI) Coordinator; registered staff; personal support workers (PSW) and residents.

During the course of this inspection, the inspector (s) observed the provision of resident care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures and Critical Incident System (CIS) submission.

Stacey Guthrie, Inspector #750 was present during this Critical Incident inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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).

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 care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) was submitted to the Director on an identified date, related to a fall sustained by resident #002. A clinical record review indicated that resident #002 was assessed. The plan of care that comprised the care plan, included an intervention; with the intent to provide assistance.

During an interview on an identified date, staff #100 stated that resident #002 had an intervention to prevent falls. During an interview on an identified date, the Director of Resident Care (DRC) confirmed that the intervention was not in place as per the plan of care. The DRC stated that care set out in the plan of care related to the intervention was not provided to resident #002 as specified in the plan. [s. 6. (7)]

2. The licensee failed to 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, b) the resident's care needs change or care set out in the plan is no longer necessary.

A Critical Incident System (CIS) was submitted to the Director on an identified date, related to a fall sustained by resident #003. A clinical record review included a progress note, that indicated resident #003 had a fall and was assessed. A progress note indicated that resident's #003 was reassessed subsequently and had a decline in condition. Further record review revealed registered nurse (RN) #103 assessed resident #003 and also noted the change in health condition. Additional progress notes, indicated that resident #003 continued to decline in their health condition.

During an interview on an identified date, RN #103 stated that additional assessments were not initiated in relation to the decline in resident's #003 health condition. During an interview on an identified date, the DRC stated that more frequent assessments should have commenced at the time resident's #003 health condition was noted to decline. The DRC stated that they failed to revise the plan of care when resident's #003 care needs changed. [s. 6. (10) (b)]

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 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 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 the Act or the Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 49. (1) the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A Critical Incident System (CIS) log was submitted to the Director on an identified date, related to a fall sustained by resident #003. A clinical record review included a progress note that indicated resident #003 had a fall and was assessed. A progress note indicated that resident's #003 subsequent assessment indicated their health condition declined. Further record review included a progress note that RN #103 assessed resident #003, and noted their health condition had declined. Additional progress notes, indicated that resident's #003 health condition further declined. RN #103 documented a progress note that the physician was contacted regarding resident's #003 health condition when they further declined.

During an interview on an identified date, RN #103 stated that the physician was not called immediately in relation to resident's #003 decline in condition. During an interview on an identified date, the DRC stated that the physician should have been notified immediately when resident's #003 condition declined. The home did not comply with their policy, which was part of the licensee's falls prevention and management program. [s. 8. (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 where the Act or the Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

Issued on this 18th day of March, 2019

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

Original report signed by the inspector.