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 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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 25, 2017 | 2016_419658_0013 | 028004-16, 030414-16, 030415-16, 030857-16, 031648-16, 000391-17, 003230-17 | Critical Incident System |

**Licensee/Titulaire de permis**

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

**Long-Term Care Home/Foyer de soins de longue durée**

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

NEIL KIKUTA (658)

## 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): December 21, 22, 2016, January 4, 6, 10, 30, 31, February 1, 2, 9, 10, 14, and 15, 2017.**

**A Written Notification (WN #1), and Compliance Order (CO #001) under O. Reg. 79/10, s. 50 (2), identified in this inspection will be issued under a Complaint Inspection #2016_419658_0015 concurrently inspected during this inspection.**

**A Written Notification (WN #2), and Voluntary Plan of Correction (VPC #2) under LTCHA, 2007, c. 8, s. 6 (10), identified in this inspection will be issued under a Complaint Inspection #2016_419658_0015 concurrently inspected during this inspection.**

**A Written Notification (WN #3) and Compliance Order (CO #001) under LTCHA, 2007, c. 8, s. 24 (1), identified in this inspection will be issued under a Complaint Inspection #2016_254610_0035**
**concurrently inspected during this inspection.**

**The following intakes were completed within this Critical Incident System Report:**

**Critical Incident Log #028004-16, CIS #2643-000025-16, related to prevention of abuse and neglect;**
**Critical Incident Log #030414-16, CIS #2643-000028-16, related to prevention of abuse and neglect;**
**Critical Incident Log #030415-16, CIS #2643-000029-16, related to prevention of abuse and neglect;**
**Critical Incident Log #030857-16, CIS #2643-000009-17, related to prevention of abuse and neglect;**
**Critical Incident Log #031648-16, CIS #2643-000032-16, related to prevention of abuse and neglect;**
**Critical Incident Log #000391-17, CIS #2643-000001-17, related to prevention of abuse and neglect; and**
**Critical Incident Log #003230-17, CIS #2643-000005-17, related to prevention of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Staff Educators, one Registered Nurse, five Registered Practical Nurses, three Personal Support Workers, and 11 residents.**

**The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies, procedures, and program evaluations, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, and staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**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)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A treatment transcribed in the prescriber's order form on a specified date directed staff to complete a dressing change on specific days for four weeks. The directions for the treatment were in relation to an identified resident's area of altered skin integrity.

On a specified date, an inspector observed an identified Registered Practical Nurse (RPN) complete a dressing change for the identified resident. When asked what type of dressing they used, the identified RPN replied that they used a different type of dressing for the area of altered skin integrity because they did not have the dressing as prescribed by the physician.

When this was brought forward to an identified Staff Educator, they stated that the identified RPN had utilized the wrong dressing, but that the treatment cart did in fact contain multiple packs of the correct dressing for the area of altered skin integrity.

The Director of Care acknowledged that the identified RPN had not applied the correct dressing, and stated that it was a requirement to follow the directions in the physician's order.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to minimal harm or potential for actual harm. There was a history of unrelated non-compliance in the last three years. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident was afforded privacy in treatment and in caring for their personal needs.

On a specified date, two inspectors observed from the hallway a Personal Support Worker (PSW) providing care to an identified resident who was in their bed while the resident's door was still open. Inspectors were able to hear from the hallway a conversation between the PSW and the identified resident.

Internal investigation notes related to the Critical Incident System (CIS) Report, after the Inspectors brought forward the concern, identified that the PSW could not recall if they had closed the door completely, and the PSW stated that the door sometimes opened by itself.

When the inspectors reported the incident to the Administrator, the Administrator said that the door should have been closed while the resident was being provided care.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level one, related to minimum risk. There was a history of unrelated non-compliance in the last three years. [s. 3. (1) 8.]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b).

On a specified date, an identified Staff Educator notified the Ministry of Health and Long-Term Care of an incident that occurred at the home via the after-hours emergency contact number. The incident report indicated that a staff member had allegedly failed to provide care, and was put off work pending investigation.

On a specified date, an identified Staff Educator explained that they had started the investigation the next day after the allegation was brought forward, and talked to the staff and residents involved. The identified Staff Educator stated that the identified staff member was supposed to come for an interview, but a family emergency had delayed the investigation for a month.

The results of this investigation were not reported to the Director in a Critical Incident System (CIS) report until February 13, 2017. The identified Staff Educator explained that they did not have access to submitting a Critical Incident System (CIS) report, and that the Administrator should have submitted one.

On a specified date, the Administrator acknowledged that there was no CIS report completed indicating the results of the investigation, and that it was their expectation that it should have been done.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level one, related to minimum risk. There was a history of unrelated noncompliance in the last three years. [s. 23. (2)]

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**Issued on this 18th day of July, 2017**

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

**Original report signed by the inspector.**