Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Sep 19, 2019	2019_788721_0031	015691-19, 016343-19	Complaint

Licensee/Titulaire de permis

Meadow Park (London) Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Meadow Park (London)
1210 Southdale Road East LONDON ON N6E 1B4

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

MEAGAN MCGREGOR (721)

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): August 27 and 28, 2019.

The following Complaint intakes were inspected during the course of this inspection:

Complaint IL-69206-LO/Log #015691-19 and Complaint IL-69495-LO/Log #016343-19 related to concerns regarding a resident being discharged from the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Medical Director (MD), Personal Support Workers (PSWs) and two representatives from the Local Health Integration Network (LHIN).

The Inspector also reviewed clinical records and plans of care for identified residents and documentation related to the homes discharge process.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that in the case of a resident who was absent from the home, they were informed by a resident's physician or registered nurse in the extended class attending to the resident that the resident was being discharged from the home.

The Ministry of Long-Term Care (MOLTC) Action Line received complaint IL-69206-LO and IL-69495-LO related to concerns of resident #001 being discharged from the home while the resident was in hospital on a psychiatric leave. As per these complaints, resident #001 was admitted to hospital on a specific date and was informed by the home 55 days later that they were being discharged.

A review of resident #001's progress notes in PointClickCare (PCC) showed the following:
- A progress note on a specific date and time that stated resident #001 was taken to hospital on a Form 1.
- A progress note dated 20 days after resident #001 was admitted to hospital stated the hospital called to provide an update on resident #001 and informed that there had been no issues with them in hospital and the attending physician was hoping for a quick discharge.
- A progress note dated 48 days after resident #001 was admitted to hospital and written by Administrator #100 documented a call between them, the physician and Registered Nurse (RN) attending to resident #001 in hospital, a representative from the LHIN and staff at Meadow Park London including MD #103, DOC #101 and PSW #102. Writer stated that the attending physician in hospital advised they felt resident #001 was ready to return to Meadow Park London and Administrator #100 requested a report from them

to make an informed decision to accept their return or discharge resident #001 from Meadow Park London.
- A progress note dated 48 days after resident #001 was admitted to hospital and written by MD #103 documented a call between them, the physician and RN attending to resident #001 in hospital, the Social Worker (SW) in hospital, a representative from the LHIN and staff at Meadow Park including Administrator #100, DOC #101 and PSW #102. Writer stated that the attending physician in hospital advised that based on their behaviour in hospital they felt they could not keep resident #001 in hospital and would have to transfer them back to the home. Writer further stated that the call ended with the attending physician in hospital asking Meadow Park London staff to decline resident #001's transfer back to the home and that Administrator #100 requested 24 hours to discuss grounds for refusal with licensee.
- A progress note dated 55 days after resident #001 was admitted to hospital and written by DOC #101 documented a discussion with resident #001's Power of Attorney (POA). Writer stated they advised resident #001's POA that resident #001 would not be returning to Meadow Park London as per phone conversation with the LHIN and hospital.

A review of resident #001's physical chart included handwritten notes by Administrator #100 from a meeting between them, the attending physician and RN in hospital, a representative from the LHIN, and Meadow Park London staff that occurred 48 days after resident #001 was admitted to hospital, which indicated that resident #001's attending physician in hospital stated they believed resident #001 was ready to return to the home.

On a specific date, Administrator #100 provided Inspector #721 with a copy of a discharge letter addressed to resident #001 and their POA. The discharge letter was signed and dated by Administrator #100 on a specific date that was 54 days after resident #001 was admitted to hospital and stated they had made the decision to discharge resident #001 from Meadow Park London.

During an interview on a specific date, when asked who made the decision to discharge resident #001 from Meadow Park London, Administrator #100 said it was a collective decision between them and DOC #101. Administrator #100 stated they made the decision to discharge resident #001 after receiving information from the hospital on a specific date that was 49 days after resident #001 was admitted to hospital. When asked who informed the resident of their discharge from Meadow Park London, Administrator #100 said the hospital had informed resident #001 that they had been discharged.

During a telephone discussion on a specific date, when asked who made the decision to

discharge resident #001 from Meadow Park London, LHIN Representative #105 stated that they were informed on a specific date that was 55 days after resident #001 was admitted to hospital, by Administrator #100 that they had decided to discharge resident #001. When asked if the physician or nurse in the extended class attending to resident #001 in hospital was part of the decision-making process and in agreeance with the decision to discharge the resident, LHIN representative #105 stated the physician attending to resident #001 was not in support of the discharge.

The licensee has failed to ensure that they were informed by resident #001's attending physician or registered nurse in the extended class that resident #001 was being discharged from the home. [s. 145. (2) (b)]

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.