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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 10, 2024

Inspection Number: 2024-1151-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Meadow Park (London) Inc.

Long Term Care Home and City: Meadow Park (London), London

Lead Inspector	**Inspector Digital Signature**
Melanie Northey (563)	Melanie Northey Digitally signed by Melanie Northey Date: 2024.04.10 16:02:06 -04'00'

Additional Inspector(s)
Rhonda Kukoly (213)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 8, and 9, 2024
The inspection occurred offsite on the following date(s): April 3, 2024

The following Critical Incident (CI) intakes were inspected:

- Intake: #00107267 [CI #2643-000003-24] related to Prevention of Abuse and Neglect
- Intake #00107528 [CI #2643-000005-24] related to Falls Prevention and Management

The following Complaint intakes were inspected:

- Intake # 00109409 [IL-0123197-LO] Complaint related to Prevention of Abuse and Neglect

The following intakes were also completed:

- Intake: #00112161 [CI #2643-000014-24] related to Falls Prevention and Management
- Intake: #00112160 [CI #2643-000015-24] 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

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure that a resident's right to proper care and services was fully respected and promoted and consistent with their needs.

Rationale and Summary
A resident's right to proper care was not fully respected and promoted and was not consistent with their needs.

The Director of Care stated the resident required more assistance and the resident's right to proper care was not fully respected and promoted and was not consistent with their needs. The Personal Support Worker (PSW) failed to provide the proper care and services required by the resident.

Sources: home's investigation notes and interviews, observations, resident clinical record review; and resident and staff interviews. [563]

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 failed to ensure that the fall prevention care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
A resident's care plan identified the use of a specific fall prevention strategy, however the resident was observed and the strategy was not implemented. The PSW and the Restorative Care Aide stated the resident was assessed for the use of the fall prevention strategy, it was documented as part of the care plan and the

strategy should have been implemented at the time of the resident observation. The resident was at risk for injury if they were to sustain a fall.

Sources: resident clinical record review, observations, and resident and staff interviews. [563]