Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 3, 2021	2021_747725_0001	000876-21, 001626-21, 001629-21, 001633-21	Complaint

Licensee/Titulaire de permis

Meadow Park (Chatham) 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 Nursing Home (Chatham)
110 Sandys Street Chatham ON N7L 4X3

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

CASSANDRA TAYLOR (725), AMIE GIBBS-WARD (630)

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): Feburary 8-11, 17, 2021

The following complaint intake was inspected during this inspection;

Log #: 000876-21 - relating to allegations of abuse and neglect, continence care, physiotherapy care plan and maintenance of the building.

The following Critical Incident Systems Report intakes were inspected during this inspection;
Log #: 001626-21 - CIS 2685-000002-21 - relating to allegations of neglect
Log #: 001629-21 - CIS 2685-000003-21 - relating to allegations of abuse
Log #: 001633-21 - CIS 2685-000004-21 - relating to allegations of neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Co-Director of Care, two Registered Nurses, four Registered Practical Nurses, two Personal Support Workers, one Physiotherapist, one Physiotherapist assistant, one Cook, one Environmental Services Supervisor, one Housekeeper.

The inspector reviewed relevant resident care records, policy and procedures and cleaning schedules, Critical Incident System reports and completed relevant observations of staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

4 WN(s)
4 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care for a resident that set out the planned care, the goals the care was intended to achieve and provided clear directions to staff related to physiotherapy care.

Physiotherapist (PT) #110's assessment that was documented, indicated they had received a referral for the resident and requested the physiotherapy staff work with the resident to improve their range of motion (ROM). This assessment stated that the Physiotherapy Assistants (PTAs) would encourage the resident to participate in group exercise classes in order to maintain the resident's available ROM in all key joints. PTA #109 said they thought the resident started in the home's general exercise program at some point between a certain date range, but they were not exactly sure when this had occurred. The general exercise program for the resident was described by PT #110 and PTA #109 as one to one care to support their strength and ROM. This care was described as including hands on assistance from the PTAs with movement of upper and lower extremities. PT #110 and PTA #109 also said that the resident's diagnosis impacted on their physiotherapy assessments and care at times and they needed to re-approach the resident or use techniques to encourage their participation.

The written plan of care for the resident did not include the planned physiotherapy care,

the goals of that care or provide clear direction for staff related to the resident's individual care needs and interventions in the exercise program. PT #110 said usually resident's who were in the general exercise program did not have a written plan of care, as it was just a general approach to care applied to all residents who wished to partake. PT #110 said that due to COVID-19 restrictions the home's group exercise program had been changed in 2020, and the PTAs were instead providing this form of physiotherapy care to residents through one to one exercise assistance. As the care plan in PCC was described as the primary means by which the PTAs would be kept informed of residents' individual care needs based on the PT's assessments, the absence of a physiotherapy care plan placed the resident at risk for not receiving the physiotherapy care they required.

Sources: Residents care plan and other clinical records; interview with relevant sources; interviews with PT #110 and other staff. [s. 6. (1)]

2. The licensee has failed to ensure there was a written plan of care for the resident that set out the planned care, the goals the care was intended to achieve and that provided clear directions to staff related to the use of an intervention that had been placed in their bedroom.

On observation resident was observed to have a intervention in their shared bedroom. Registered Nurse (RN) #107 said this intervention was part of the resident's fall prevention interventions and had been purchased by the resident's Power of Attorney (POA) sometime in 2020 at the request of the staff in the home. RN #107 said they thought this intervention was kept on at all times but they did not tend to use it regularly during the day shift. They thought the intervention was utilized more by the staff on the night shift to monitor the resident in order to help prevent falls. RN #107 said there was no specific expectations or practices for monitoring the resident using this intervention and they were not sure how effective this intervention had been related to falls prevention.

The plan of care for the resident did not include this intervention, the goal this intervention intended to achieve and did not provide direction for staff regarding when and how to use of the intervention until it was added in February, 2021. When this intervention was added to the plan of care it indicated that it was to be positioned a certain way, but it did not provide further direction to staff. As this intervention was implemented without clear direction for staff, there was a risk that the residents. This lack of direction in the care plan also placed the resident at risk for falls as there was not clear

direction for staff on how this was to be utilized as part of their falls prevention strategies.

Sources: Observations February, 2021; the residents progress notes and other clinical records; interviews with Registered Nurse (RN) #107 and other staff. [s. 6. (1)]

3. The licensee has failed to ensure there was a written plan of care for two residents that set out the planned care, the goals the care was intended to achieve and that provided clear directions to staff related to the use of an intervention that had been placed in their shared bedroom.

On observation, a resident was observed to have an intervention in their shared bedroom. RN #107 said this intervention was part of the interventions for the resident's room mate, related to a diagnosis and concerns with the risk of the diagnosis negatively affecting co-residents. They said there was no specific expectations or practices for monitoring the residents.

The plan of care for the residents did not include this intervention, the goal this intervention intended to achieve and did not provide direction for staff regarding when and how to use of the the intervention. As this intervention was implemented without clear direction for staff, there was a risk that the residents in that room. This lack of direction in the care plan also placed the resident at risk for harm from their co-resident, as there was not clear direction for staff on how this was to be utilized as part of the residents care strategies.

Sources: Observations February, 2021; resident's progress notes and other clinical records; interviews with Registered Nurse (RN) #107 and other staff. [s. 6. (1)]

4. The licensee has failed to ensure that residents and their substitute decision makers were given an opportunity to fully participate in the development and implementation of the resident's plan of care regarding testing for Covid-19.

The home was declared in a Covid-19 outbreak on January 22, 2021. A complainant stated that they were not contacted to obtain consent prior to their family member a resident, receiving a Covid-19 swab. They were informed after the swab had already been completed in January, 2021. During an interview with the DOC and Administrator, both indicated that no Substitute Decision Makers (SDM) were phoned to obtain consent and all residents were swabbed for safety measures.

Not consulting residents or their SDMs posed a minimal risk for them and did not allow them to fully participate in decision making about having a Covid-19 swab completed.

Sources: Resident #001 progress notes and staff interviews with the DOC and Administrator. [s. 6. (5)]

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 residents and their substitute decision makers are given an opportunity to fully participate in the development and implementation of the resident's plan of care regarding testing for Covid-19., 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 has failed to ensure that the home was maintained in a good state of repair.

Observations of the residents' shared spaces in the East, West and North areas of the home on February 8 and 9, 2021, found the following:
- scraped wall paint and damaged walls and baseboards throughout the hallways and

main dining room;
- scraped paint on door frames and doors;
- damaged and stained ceiling tiles throughout the hallways;
- damaged areas on the ceiling in the main dining room;
- damaged and stained light fixtures in the main dining room;
- stained and damaged flooring in the hallways and main dining room;
- a broken section of the hand railing in the North hallway;
- damaged areas on the cabinet in the main dining room and scraped paint on the cabinet in the West dining room.

Observations of three resident bedrooms/bathrooms in February, 2021, found the following:
- On the North unit a room, had stained damaged floor and chipped paint on window ledge;
- On the East unit a room , scraped paint on walls, bathroom door and radiator/heater cover, stained flooring, a damaged screen with dirt and dust build-up between the screen and window;
- On the West unit a room, scraped paint on bathroom door and door frame, damaged flooring, scraped wall paint and damaged areas on the wall.

The Environmental Services Supervisor (ESS) said the home had a preventative and remedial maintenance program in place which included regular audits of resident common areas and resident bedrooms/bathrooms. The ESS said through audits and observations they had also identified areas of the home which required painting or repair and they tried their best to prioritize which areas were repaired based on risk to resident safety. The ESS and Inspector #630 observed pictures of the areas of disrepair identified during the inspection, and the ESS acknowledged that this did not meet their expectations for the home's state of repair. The ESS said the home had plans to continue working on painting common areas and resident rooms, replacement and repair of ceiling tiles, window repairs and flooring repairs. The areas of disrepair identified through the inspection were not considered a safety risk to the residents in the home.

Sources: Observations February, 2021; maintenance record review including Maintenance Room Inspections January 2021; interviews with the Environmental Services Supervisor and other staff. [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 home is maintained 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that allegation of abuse or neglect of a resident were investigated and appropriate actions taken immediately.

Two Critical Incident System (CIS) reports were submitted to the Ministry of Long-term Care (MLTC). A CIS report outlined an incident that involved a resident and allegations of neglect with a specific incident date. Another CIS report outlined an incident that involved a resident and allegations of abuse with the incident occurring on another specific date.During record review the inspector was unable to review the homes investigation review. It was confirmed during an interview with the Director of Care (DOC) that an investigation was not completed for either CIS report incident.

Not immediately investigating allegation of abuse or neglect posed a potential risk to the resident.

Sources: CIS reports, Resident record review and staff interviews with the DOC. [s. 23. (1) (a)]

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 allegation of abuse or neglect of any resident are investigated and appropriate actions taken immediately, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of abuse or neglect for a resident was reported immediately to the Director.

Two CIS reports were submitted to the MLTC on a specific date. A CIS report outlined an incident that involved a resident and allegations of neglect. The incident date was noted as 10 days prior to the submission date. During record review of the homes online charting system Point Click Care (PCC) progress notes it indicated the home was aware of the allegations 10 days prior to the submission date prior to the submission date.

Another CIS report outlined an incidents that occurred 21 days prior to the submission date, with a resident. During record review in the PCC progress notes for the resident it indicated that allegations were brought forward to the staff and the Director of Care (DOC) the day after the incident and 20 days prior to the submission date.

During an interview with the DOC it was indicated that both incidents should have been reported immediately.

Not reporting certain matters to the Director within the required time frame posed a minimal potential risk.

Sources: CIS reports, Resident record review and staff interviews with the DOC. [s. 24. (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 any allegations of abuse or neglect for any resident is reported immediately to the Director, to be implemented voluntarily.

Issued on this 8th day of March, 2021

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

Original report signed by the inspector.