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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2016	2016_216144_0017	001552-16	Complaint

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

CAROLEE MILLINER (144)

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): February 17, 2016

The inspection was related to the plan of care and duty to protect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co Director of Care (Co DOC) and two Registered Practical Nurses (RPN's).

During the course of the inspection, one letter of complaint dated January 4, 2016, one inquiry and intake record and one resident clinical record were reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Legendé 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) One resident was admitted to the home with a physician's order consistent with their diagnosis.

B) A written letter of complaint from the complainant included concerns related to the resident's plan of care not being followed.

C) Review of the resident's clinical record during their time of admission revealed the plan of care was not followed on two occasions.

D) One RPN staff #103 confirmed the resident's plan of care should have been followed in accordance with the physician's order.

E) The Administrator staff #101 confirmed the resident's plan of care should have been followed in accordance with the physician's order and that the care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

A) The home's policy for Admission of Residents, effective September 16, 2013 included the following directive:
"The Registered Staff member will: complete each item on the checklist noting the completion of same by initialing & dating the item; follow up on any outstanding items on the checklist that are incomplete & notify the DOC or delegate of same."

B) The Nursing Admission Checklist and Audit that were part of the Admission of Resident's policy included the requirement for specific resident information to be entered into the point click care program on day one of a resident's admission to the home.

C) Review of one resident's clinical record revealed that during the resident's stay at the home, the Nursing Admission Checklist and Audit was not followed with respect to two items that are required on day one of admission.

D) RPN's staff #'s 103 and 104 confirmed the two identified items should have been completed and recorded in their clinical record within twenty-four hours of admission.

E) The Administrator staff #101 and the DOC staff #100 confirmed the Admission of Residents policy and checklist was not followed and that the two identifed items were not completed and recorded in their clinical record during their stay at the home. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A) Review of the clinical record for the one resident revealed progress notes were not recorded for the resident on the date of admission to the home.

B) RPN's, #'s 103 and 104, advised progress notes should have been completed on all three shifts on the date of admission that included information about the resident related to their diagnosis, known allergies, where they were admitted from, how they were admitted, who accompanied them and, assistance the resident needed with activities of daily living.

D) The DOC staff #100, confirmed the home did not have a policy that provided direction to registered staff to document specific information in the progress notes on the date of admission however, would expect to see documentation related to where the resident came from, who they were accompanied by, did they walk in or other, overall appearance and condition, medical diagnosis, known allergies, something about their activities of daily living , if they were orientated to their room, the call bell system and meals.

E) The Co DOC staff #102 concurred with the DOC's expectations for documentation in the resident's progress note section of their clinical record on the date of admission.

F) The Administrator staff #101, confirmed the DOC's expectations for documentation in the progress notes on the date of admission and agreed the resident's written record was not kept up to date. [s. 231. (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 resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 4th day of March, 2016

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

Original report signed by the inspector.