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

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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
Jul 11, 2016	2016_457630_0026	012812-16	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

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): July 5, 6 & 7, 2016.

The following Complaint inspection was conducted:
012812/16/IL-44470-LO – Complaint related to alleged staff to resident verbal abuse

A Written Notification and Voluntary Plan of Correction issued in this report originated from other complaint inspections as follows:
Complaint Inspection report #2016_457630_0028 with log #005726-16 for the following:
O. Reg 101 (1)1. Licensee failed to investigate verbal complaints.

Complaint Inspection report #2016_457630_0027 with log #006440-16, 005993-16 & 008653-16 for the following:
O. Reg 101 (2) Licensee did not keep written records of complaints in the home.

The following intakes were inspected at the same time as this Critical Incident inspection and can be found in separate reports:
004345-16/CI 2643-000009-16 - Critical Incident related to alleged staff to resident abuse
005726-16/IL-43320-LO, IL43189-LO & IL43580-LO – Complaint related to alleged staff to resident verbal abuse, multiple personal care issues and housekeeping
006440-16/IL-43241-LO & IL-43625-LO – Complaint related to alleged neglect, pain management, medication administration and multiple personal care issues
008653-16/IL-43315-LO & IL-43385-LO – Complaint related to resident's bill of rights
005993-16/IL-43300-LO – Complaint related to alleged staff to resident verbal abuse
018957-16/HLTC2966MC-2016-6116 – Complaint related to alleged staff to resident abuse

Inspector #635 (Charles Smith) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Director of Care, the Food Services Supervisor, the Staff Educator, the Resident Family Staff Coordinator, the Quality Nurse, one Registered Nurse (RN), one Registered Practical Nurse (RPN), six Personal Support Workers (PSWs), one Dietary Aide, one family member and three residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed staff education records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
2 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care set out clear direction to staff and others who provided direct care regarding dressing and transferring the resident.

During an interview with an identified resident it was reported that there were concerns regarding staff not providing the assistance required for getting dressed and the approach for transferring the resident.

Observations of the room for this identified resident found the the care cards posted in the room did not reflect the care required and did not match other parts of the clinical record.

During an interview with multiple staff members it was reported that they would look on the care cards and the plan of care in the computer to find out the care a resident required. The staff reported this resident had different care requirements than what was listed in the plan of care and care cards.

Review of the clinical record for this identified resident found the progress notes indicated concerns from staff and the resident regarding the care approach for dressing. This review also found the plan of care did not provide clear direction to staff regarding the care needs for the resident.

During an interview with the Administrator it was reported that it was the expectation of the home that the plan of care would provide clear direction for staff for dressing this identified resident. Reviewed plan of care for this resident with Administrator and it was acknowledged that it did not provide staff with clear direction regarding the level of assistance and approach required for dressing. [s. 6. (1) (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 with ensuring the plan of care sets out clear direction to staff and others who provided direct care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there were investigations into the verbal complaints made by resident #007 when the resident lived in the home.

Review of Complaint Inspection Intake log #005726-16 found that an identified resident had reported multiple care concerns to the Ministry of Health and Long Term Care (MOHLTC) Action Line.

During an interview with an identified staff member of the home it was reported that this resident had expressed verbal concerns about the way staff members had treated the resident.

Review of clinical record for this identified resident found documentation that concerns had been expressed to a member of the management team regarding the treatment

he/she had received from staff in the home. An interview with this staff member confirmed that this resident had expressed concerns with how a staff person spoke with him/her.

During an interview the Administrator reported having been aware of some concerns that had been expressed by this identified resident. It was acknowledged that there had been another resident in the home who had similar concerns. The Administrator said the same concern had not been expressed by this identified resident, but said it could have occurred and the resident just did not bring it forward. The Administrator said there was no documentation in the home regarding complaints that this resident had expressed to staff apart from the notes in Point Click Care.

The interviews and record reviews showed that this resident had complaints about the treatment received from staff and that these complaints had been expressed verbally to staff and management in the home. Based on the documentation provided by the home the management did not start an investigation or document the complaints as per the home's policy or the legislation. [s. 101. (1) 1.]

2. The licensee has failed to ensure there was a documented record kept in the home related to the complaint made to the home for resident #002.

Record review showed that the family of an identified resident had called and spoken to a staff member of the home regarding concerns about the approach a staff member had used to care for the resident.

During an interview with the Administrator it was reported that they were having difficulties locating documentation in the home regarding the investigation and follow-up to the concerns expressed by the family of this identified resident. The Administrator said based on the information she was able to provide it was clear that the process for dealing with this complaint was not completed as per the home's policy. The Administrator said based on a review of this information the home viewed it as a complaint versus verbal abuse and dealt with it in that way. The Administrator said they had discussed the family concern at a care conference but agreed that the documentation did not reflect that discussion.

Review of the complaints records provided by the Administrator regarding the concern found they did not include a full record of management's investigation into the concern, the follow-up that occurred with the resident or family member, the resolution to the

concern, the dates of response to the complainant or any response from the complainant. [s. 101. (2)]

3. The licensee has failed to ensure there was a documented record kept in the home related to the complaints made to the home regarding care for resident #004.

A record review showed that the Administrator received letters with multiple care concerns from a family member of an identified resident.

During an interview with the Administrator it was reported that the staff and management in the home had ongoing discussions with this resident and the family regarding their care concerns. The Administrator said the home viewed the letters as "communication tools" versus formal complaint letters. It was also reported that after reading the letters and meeting with the family the management identified it was identifying concerns with inappropriate care but did not assess it to be alleged abuse or neglect and therefore dealt with it as a complaint.

During an interview with the Administrator it was reported that the home was having difficulties locating documentation in the home regarding the investigation and follow-up to the concerns expressed by the family of this resident. The Administrator said based on the documentation available for the inspectors it suggested the process for dealing with this complaint was not completed as per the home's policy. She said she thought the management and health care team had done a good job responding to the needs and concerns for this resident but acknowledged that the documentation available at the time of inspection did not reflect the work that had been done in the home or meet their own policies regarding the handling complaints in the home.

Review of the complaints records provided by the Administrator regarding the complaints found they did not include a full record of management's investigation into the concerns, the follow-up that occurred with the resident or family member, the resolution to the concerns, the dates of response to the complainant or any response from the complainant. [s. 101. (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 with ensuring that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

Issued on this 25th day of July, 2016

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

Original report signed by the inspector.