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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 28, 2017	2016_254610_0034	018346-16, 020244-16	Critical Incident System

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 6 and 7, 2016.

This critical incident was inspected related to Falls Prevention, and Hospitalization and Change in Condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Co-Director of care, Restorative Care Manager, two personal support workers and a Registered Nurse.

Inspector also toured the resident home areas and common areas, observed resident care provision, resident/staff interaction, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 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 :

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

1) O. Reg. 79/10, s. 30 (1). states that every licensee shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O. Reg.79/10, s. 49(1) states that every licensee shall ensure that the falls prevention and management program must, at a minimum, provide for the strategies to reduce or mitigate falls, including the monitoring or residents, the implementation of the restorative care approaches and the use of the equipment, supplies, devices and assistive aids.

The licensee's Falls Prevention and Management Program Policy Revised 2014-11-11 showed that the care plan should be updated to reflect current interventions and that the interventions were revised if ineffective.

A) Review of an identified resident's admission documentation showed that the resident had poor judgment making skills that resulted in falls incidents.

The high risk for falls plan of care for the resident was not developed until a few days after being admitted to the home and after the resident had already fallen.

The licensee's 24 hour Plan of Care Policy Revised 2015-07-21 stated in part that the nurse was to ensure the plan of care was on the electronic record within twenty-four hours of admission and if any risk was identified for falls that the resident may pose to himself or herself, it was to be included in the twenty-four hour plan of care with interventions to mitigate those risks.

The resident sustained a fall at which time the resident reported that they had injured themselves and had skin integrity issues. A review of the documentation showed that the interventions and notification to the physician were not completed and left blank in the assessment. The plan of care was not revised to include any interventions for the

resident.

The resident had fallen three more times in a 24 hour period and the documentation in the health care record showed that the resident had interventions in place but were not effective interventions.

Review of the assessment documentation for four out of five assessments was incomplete and there were no additional interventions implemented to mitigate risk to the resident.

The DOC said that the post fall assessment should have been completed in full for every fall incident and that the admission assessment and plan of care should be implemented within twenty-four hours of admission addressing the high risk for falls.

The DOC also said that the resident should have had interventions and strategies implemented to mitigate the falls, including monitoring of the resident, and implementation of restorative care approaches and the use of devices and that the policy should have been complied with.

B) Review of another resident's plan of care showed the resident was admitted to the home and had poor decision making processes and an increased risk of falls incidents.

The care plan initiated showed that the resident was at risk for falls characterized by history of falls. The resident had interventions in the care plan that were to be in place for falls prevention.

The resident’s RAI MDS indicated the resident had no falls however, the resident had several falls that should have been documented on the assessment.

The resident sustained an unwitnessed fall and the post fall assessment showed that the interventions that were used were not documented in the plan of care and the interventions that were documented in the post fall assessment were not used.

A few days later the resident sustained another unwitnessed fall with injury. The post fall assessment showed a referral to restorative care for an identified interventions however, the previous post fall assessments already identified were already in place for the resident.

The resident had two more falls both were unwitnessed. The resident sustained skin integrity issues and the post fall assessments showed that only one documented intervention had been implemented from the plan of care.

Further review of the documentation for the resident showed that on at least three occasions there was no head injury routine documentation.

The resident had another unwitnessed fall and resident sustained an injury. The assessment showed that the resident had one intervention in place and the plan of care was not followed for this resident. The resident was transferred to hospital.

The Administrator said that when current interventions in the plan of care were not effective, the resident should have been reassessed per the Falls Prevention and Management Program Policy.

The licensee failed to ensure that the Falls Prevention and Management Program Policy was complied with.

The Severity of Risk was potential for risk of harm the scope was a pattern there was previous compliance history in the home issued inspection #2016_262523_0010 as a Written Notification and a Voluntary Plan of Correction on February 17, 2016.

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 was instituted or otherwise put in place was complied with, to be implemented voluntarily.

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.