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

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 public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 17, 2017	2016_254610_0035	027003-16, 030802-16, 030906-16, 033785-16, 033880-16, 004430-17, 006739-17	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

NATALIE MORONEY (610)

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): January 30, 31, February 1, and March 30, 31, 2017.

The following Complaint inspections were conducted concurrently during the course of this inspection:

Complaint Log #027003-16 IL #46493-LO related to prevention of abuse and neglect
Complaint Log #030802-16 IL-#47518-LO related to prevention of abuse and neglect
Complaint Log #033880-16 IL #48305-LO related to prevention of abuse and neglect
Complaint Log #033785-16 IL #48278-LO related to prevention of abuse and neglect

The following Critical Incident inspections were conducted concurrently during the course of this inspection:

Critical Incident Log #028004-16 CIS #2643-000025-16 related to prevention of abuse and neglect
Critical Incident Log #030414-16 CIS #2643-000028-16 related to prevention of abuse and neglect
Critical Incident Log #030415-16 CIS #2643-000029-16 related to prevention of abuse and neglect
Critical Incident Log #030857-16 CIS #2643-000009-17 related to prevention of abuse and neglect
Critical Incident Log #031648-16 CIS #2643-000032-16 related to prevention of abuse and neglect
Critical Incident Log #000391-17 CIS #2643-000001-17 related to prevention of abuse and neglect
Critical Incident Log #003230-17 CIS #2643-000005-17 related to prevention of abuse and neglect
Critical Incident Log #004430-17 CIS #2643-000010-17 related to prevention of abuse and neglect
Critical Incident Log #006739-17 CIS #2643-000016-17 related to prevention of abuse and neglect
Critical Incident Log #030906-16 CIS #2643-000031-16 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care,10 Personal Support Workers, seven Registered Practical Nurses and two Registered Nurses, family, and residents.

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:
Medication
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	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. (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 :

During an interview, the complainant indicated that the resident had behaviours and often

would refuse care and treatment and there was a plan in place that the family would be notified of these behaviours.

On a specific date the complainant was contacted and provided further information regarding their initial complaint. The complainant explained that the resident had poor decision making processes related to health conditions and would often refuse treatments and care.

Review of resident plan of care, showed that resident had responsive behaviours and that the resident would refuse care and treatment. The interventions indicated that staff had to document episodes of behaviour, and were to notify the family of any refusals.

On a specific date, the physician had prescribed a medication to be administered. The medication that was prescribed was to assist with the residents underlying health conditions.

Review of the electronic medication administration record (eMAR) showed that during the 13 days the medication was to be administered, the resident had refused on several occasions, and the medication was not given. There was no documentation in the resident’s health record that showed that the physician or the family had been made aware that resident was refusing the medication and therefore they had not received the medication.

A test was ordered by the physician as the resident was experiencing an acute health condition. The next day the resident had been transferred out of the home to the hospital. Further review of the progress notes showed that the resident had received treatment due to a change in their condition.

The licensee failed to allow the family to fully participate in the development and implementation of the resident’s plan of care when the family was not notified of the refusal to take the medications.

The Severity of Risk was potential for harm, the scope was isolated there was previous non-compliance issued to the licensee with a Written Notification, and Voluntary Plan of Correction for critical incident inspection #2016_216144_0017 on February 17, 2016 and a Written Notification for inspection log #2015_217137_0011 on February 3, 2015.

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 Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care, 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 :

The licensee failed to ensure that 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 (b) is complied with. O. Reg. 79/10, s. 8 (1).

LTCHA 2007, s.20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (a) shall provide that abuse and neglect are not to be tolerated; (b) shall clearly set out what constitutes abuse and neglect; (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; (d) shall contain an explanation of the duty under section 24 to make mandatory reports; (e) shall contain

procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; (f) shall set out the consequences for those who abuse or neglect residents; (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

LTCHA 2007, s24. (1) 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.

The licensee policy for Resident Rights, Care, Services-Abuse-Zero Tolerance Revised 2015-03-23 stated in part that staff who have reasonable grounds to suspect abuse or neglect of a resident would immediately notify the most senior personnel, notify the Substitute Decision Maker (SDM), physician, and commence an immediate investigation. The Administrator or Director of Care would notify the Ministry's Regional Office via Unusual Occurrence Form within the required time frames.

The licensee policy shall follow legislative requirements in accordance to the Long Term Care Health Act and the Ontario Regulations to ensure that the duty and obligation to report mandatory and critical incidents are reported to the Director as per legislation requirements and that the unusual occurrence forms are not in accordance with the legislation.

The Administrator acknowledged that the policy for Resident Rights, Care, and Services-Abuse-Zero Tolerance was the current policy used in the home.

The licensee failed to ensure the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports.

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 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, is in compliance with and is implemented in accordance with applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #3: 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 :

The licensee failed to ensure that a person who has reasonable grounds to suspect 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 occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Ontario Regulation 79/10 defines sexual abuse as "any consensual or non-consensual

touching, behaviour or remarks of a sexual nature or sexual exploitation that was directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

The licensee policy for Resident Rights, Care, Services-Abuse-Zero Tolerance Revised 2015-03-23 stated in part that staff who have reasonable grounds to suspect abuse or neglect of a resident would immediately notify the most senior personnel, notify the Substitute Decision Maker (SDM), physician, and commence an immediate investigation. The Administrator or Director of Care would notify the Ministry's Regional Office via Unusual Occurrence Form within the required time frames as required.

The Critical Incident System (CIS) report #2643-000010-17 submitted to the Director of the Ministry of Health (MOH) showed that Director of Care (DOC) was aware of alleged sexually inappropriate touching. This incident was observed by staff, who then reported it to another staff member and then eventually reported to DOC all on the same day.

Further review of CIS #2643-000010-17 showed that the licensee did not report the abuse to the Director until three days after the incident, because the DOC viewed the alleged sexually inappropriate touching as physical abuse, and decided that this incident was not reportable to the Director. The DOC did not assess whether the incident constituted sexual abuse and did not follow the sexual inappropriate touching decision tree.

The Administrator said that the DOC was responsible to submit the critical incident related to this incident to the Director and did not. The Administrator submitted the critical incident to the Director three days after the incident.

The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding abuse of a resident by anyone.

The Severity of Harm was risk of harm, and the scope was isolated, there were findings of non-compliance for critical incident inspection # 2016_254610_0033 Log #029630-16 that had been issued as a Written Notification and Voluntary Plan of Correction, as well as an issued Written Notification on February 13, 2015, during a complaint inspection #2015_254610_0006.

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 a person who has reasonable grounds to suspect 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 occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of the resident's health care record showed the following:

On a specific date the resident returned to the home with responsive behaviours.

On three specific dates the resident was observed showing inappropriate behaviours

toward another resident.

On two specific dates the resident was attempting to enter into another residents room and was yelling at the staff.

On five specific dates the resident was verbally inappropriate towards staff. The staff documented that they spoke with a manager of the home in regards to the resident's behaviour.

On another specific date the resident was observed with inappropriate behaviours and responsive behaviours that resulted in the resident having a fall.

On another specific date the resident made inappropriate comments to another resident.

On another specific date the resident was verbally inappropriate towards a resident and their visitor and staff. The resident's behaviour was reported to the DOC, Assistant DOC and Administrator.

The resident's Health Care Record (HCR) showed that the resident had several behaviours.

The plan of care related to the resident's health condition showed they had responsive behaviours. Interventions included staff to report and document the behaviours and to monitor the resident.

During an interview with the Behaviour Support Ontario (BSO), they said that the resident had not had any external services to help manage the triggered behaviours. There were no further interventions implemented when the resident's behaviour continued to demonstrate responsive behaviours.

The DOC said that the resident should have had interventions implemented to assist the resident and staff who were at risk of harm as a result of the residents behaviours.

The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The severity of harm was risk or potential for harm, the scope was isolated there was previous non compliance issued with a Written Notification, and a Voluntary Plan of Correction from a complaint inspection #2016_254610_0011 on March 15, 2016. [s. 55. (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, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 6th day of September, 2017

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

Original report signed by the inspector.