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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2018	2018_736689_0027	010699-18, 026572-18, 028763-18, 030015-18	Complaint

Licensee/Titulaire de permis

Meadow Park (London) Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

Long-Term Care Home/Foyer de soins de longue durée

Meadow Park (London)
1210 Southdale Road East LONDON ON N6E 1B4

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

CASSANDRA ALEKSIC (689), AMIE GIBBS-WARD (630), KARIN MUSSART (145), MEAGAN MCGREGOR (721)

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): December 7, 10, 11, 12 and 17, 2018.

The following intakes were completed within the complaint inspection:

**Log #010699-18/ IL-57062-LO related to air temperature and care concerns,
Log #026572-18/ IL-60508-LO related to allegations of staff to resident abuse,
Log #030015-18/ IL-61638-LO related to related to the home's complaints process, allegations of resident neglect, falls prevention and care concerns; and
Log #028763-18/ 2643-000035-18 related to staff to resident neglect.**

The inspector(s) also observed staff to resident interactions, reviewed residents' clinical records, internal investigation notes and relevant policies and procedures of the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Registered Practical Nurse, Behavioural Supports Ontario Personal Support Worker, residents and family members.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home**

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	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), related to a complaint regarding the care provided to a specific resident, which was submitted on a specific date. The CIS report showed a critical incident date prior to that of the submitted date.

A review of the home's investigative notes showed written documentation from a phone conversation held on a specific date, between the Administrator and the resident's Power of Attorney (POA). The notes showed that the resident's POA requested a report regarding the outcome of the homes investigation into their concerns about the care that was provided to the resident after a fall. In the notes, the resident's POA said that a Registered Nurse (RN) stated at a care conference on a specific date, that the home would investigate their care concerns for the resident. The notes showed that the Administrator stated that they were on vacation at the time of the care conference and that they were not made aware of the care concerns.

A review of the resident's progress notes in Point Click Care (PCC) was completed by the inspector and showed documentation related to a care conference held on a specific date. The progress notes documented the resident's family members concerns regarding the care provided to the resident after a fall.

On a specific date, the Director of Care (DOC) stated that a RN informed the family member at the care conference that the home would investigate their concerns about the care that was provided to the resident after their fall. The DOC said that they and the Administrator were on vacation at the time of the care conference and that they were not made aware of the families concerns until a specific date, during a phone conversation between the Administrator and the resident's POA. The DOC stated that the RN did not

have access to submit a CIS report. The DOC stated that the home submitted a CIS report on the date when the Administrator became aware of the care concerns. The DOC stated that it was the homes expectation that when allegations of abuse or neglect were brought forward to staff, the staff should call the after-hours line, or call the DOC or Administrator, so they knew to submit a CIS report.

The homes policy titled "Resident Rights, Care and Services – Abuse – Zero Tolerance Policy for Resident Abuse and Neglect – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised June 2, 2017, stated the following:
-"Staff members, volunteers, substitute decision makers, family members or any other person has the right to notify the Ministry of Health and Long Term Care directly by way of the Ministry of Health Action Line posted in the home however the most Senior Administrative Personnel on site has the delegated responsibility to report to the Ministry of Health and Long Term Care immediately and will do so as required".
-"Promptly notify the Administrator and/or Director of Care of the alleged, suspected or witnessed incident of abuse or neglect if they are not the most senior administrative staff member in the home at the time of the incident."

On a specific date, the Administrator stated that they were not at the resident's care conference and did not become aware of the care concerns until they had received a call from the resident's POA on a specific date. The Administrator said that after the phone call with resident's POA, they immediately reported the allegations of neglect and began an internal investigation. The Administrator stated that it was the homes expectation that when allegations of abuse or neglect were brought forward to staff members, the allegations should be immediately reported to the Administrator or the DOC.

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect for the resident was complied with. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to the care provided to a specific resident following a fall on a specific date. The complainant stated that the home had contacted them on the date of the fall, to notify them that the resident had fallen and requested that they come to the home to assist with providing care for the resident. The complainant stated that when they arrived at the home, the resident was in their room unattended on the floor and was in distress.

The home submitted a Critical Incident System (CIS) report to the MOHLTC, related to a complaint regarding the care provided to the resident after a fall. The CIS report stated that the resident was found by staff on the floor of their room and when staff attempted to assist the resident off of the floor, they refused. The staff contacted the residents' Power of Attorney (POA) to assist with care and when the POA arrived at the home they found the resident in their room unattended on the floor.

The inspector reviewed the homes internal investigation notes regarding the fall on a specific date, which indicated that the resident was found on the floor of their room by a Personal Support Worker (PSW) at a specific time, who then informed a Registered Practical Nurse (RPN). The notes stated that the RPN attempted to take the resident's vitals, but they refused care and the PSW put the resident back into bed. The notes identified that a fall progress note was not completed related to this fall. The investigative

notes stated that the RPN found the resident on the floor again at another specific time. The notes stated that the RPN and a PSW attempted to assist the resident off the floor, but they were resistant to care and hitting staff. The notes stated that the RPN did not attempt to take resident's vitals as the resident was hitting staff and resistive to care.

Review of Progress Notes in Point Click Care (PCC) on the date of the falls, showed that the resident was found on the floor for a second time and was unwilling to allow staff to assist them to get into bed. The progress note stated that the RPN called the resident's POA for assistance and when the POA arrived they wished to have the resident sent to hospital for assessment due to possible injuries. The note stated that an ambulance was called at a specific time. An additional progress note showed that the resident was sent to hospital.

On a specific date, a Registered Nurse (RN) stated that when a resident has fallen, a post-fall assessment and follow-up fall assessment should be completed under the Risk Management tab in PCC.

Review of Risk Management in PCC for the resident showed the following:
-Incident – Type/Nature of Incident: Fall, with a specific date at a specific time.
The inspector identified that there was no additional documentation under Risk Management on this date for a second fall.

On a specific date, the RPN stated that they completed a post-falls assessment after the two falls that the resident had on a specific date, but that the post-falls assessment for the first fall was never documented in PCC. The RPN stated that when a resident has fallen it was the homes expectation that the nurse working would immediately check the resident for injuries and complete a post-fall assessment in PCC.

The home's policy titled "Residents Rights, Care and Services – Required Programs – Fall prevention and Management - Program" last revised October 22, 2018, stated the following:
"Registered staff will ensure that a resident who has a fall:
-Receives a post fall assessment prior to moving, including assessment for ROM of extremities and neck, lacerations/bruises, vital signs (including BP standing as able), HIR as indicated, and same is documented in progress notes.
-Will initiate Point Click Care Risk Management form for the fall. Referrals and progress notes may be initiated through this portal.
-Has completed a fall/post fall assessment progress note which has the results of the

post fall assessment tool transcribed into it, and reflects the circumstances of the fall. The note will also include the nursing assessment and additional interventions to be completed to prevent further falls or injury."

On a specific date, the Director of Care (DOC) reviewed the resident's clinical records and the homes internal investigation notes regarding the resident's falls. The DOC stated that there were no progress notes documenting the first fall that the resident had on a specific date. The DOC said that a post-fall assessment was attempted for both falls, but that a post-fall assessment was not documented in PCC for the second fall. The DOC stated that the expectation would be that when a resident has fallen, a post-fall assessment should have been completed immediately and documented in PCC.

The licensee has failed to ensure that when the resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments, and that the resident's responses to interventions were documented.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to the care provided to a specific resident following a fall on a specific date. The complainant stated that the home had contacted them on the date of the fall, to notify them that the resident had fallen and requested that the complainant come in to assist with providing care for the resident. The complainant stated that when they arrived at the home, the resident was alone on the floor in their room and was in distress. The complainant also stated that they had concerns regarding staff not providing the resident with scheduled baths due to resident refusal.

The home submitted a Critical Incident System (CIS) report to the MOHLTC regarding a complaint about the care that had been provided to the resident after a fall. This CIS report stated that the resident was found by staff on the floor of their room and that when staff attempted to get the resident off the floor they refused. The staff contacted the residents Power of Attorney (POA) to assist with care and when the POA arrived at the home they found the resident unattended on the floor on their room. The resident was said to have previous incidents of behaviours and had continuously refused care.

The Care Plan for the resident was reviewed in Point Click Care (PCC) and showed the resident had responsive behaviours, cognitive impairment and a communication barrier.

The Documentation Survey report v2 for the resident's behaviour was reviewed over a specific period, which showed the following:
-Records show documentation of "resistant to care" or resident refused" on 30 out of 48 (63 per cent) times.

On a specific date, a Personal Support Worker (PSW) stated that the resident had responsive behaviours and that staff often could not go near the resident to provide care. They stated that at one point the homes' Behavioural Supports Ontario (BSO) team provided the homes personal support worker staff members with a list of interventions for managing the resident's responsive behaviours, but that the list of interventions did not work. The PSW stated that when the resident refused care they would leave the resident and re-approach or ask another PSW to attempt to provide care.

On a specific date, a PSW stated that when a resident was referred to the homes BSO team, Dementia Observational System (DOS) charting was initiated for five to seven days to identify if there were any triggers for behavioural patterns and that interventions for the resident would be determined based on this charting. They also stated that any behavioural interventions in place for a resident would be documented in the residents care plan and in the communication book on the unit.

On a specific date, a RPN stated that staff were given interventions from the homes BSO team to help manage the resident's responsive behaviours and stated that no behavioural charting was in place for this resident. They also stated that they were instructed by the homes BSO team to leave the resident and re-approach when the resident was resistive to care.

On a specific date, the Director of Care (DOC) stated that the resident had been exhibiting responsive behaviours since admission to the home. The DOC said that the homes BSO team was involved with the resident and that the BSO team was documenting the resident's responsive behaviours under the Behaviour Mapping Notes in PCC. They also stated that interventions to manage the resident's responsive behaviours changed day to day and that no behavioural charting was in place for this resident.

On a specific date, a PSW stated that when a resident was referred to the homes BSO team, DOS charting was initiated for five to seven days to look at what was happening with a resident, when and why and then interventions were determined. The PSW stated

that the BSO RPN was responsible for completing behavioural assessments for a resident exhibiting responsive behaviours unless the resident was referred to an external behaviour response team for assessment. They stated that a residents behavioural assessments could be found on PCC or in their physical chart. The PSW said that the resident was being followed by the BSO team and said they could not recall whether this resident had any behavioural assessments completed. They stated that interventions were in place for this resident, and that sometimes the interventions worked and sometimes they did not depending on the staff member that approached.

The homes policy titled "Residents Rights, Care and Services – Responsive Behaviour - Program" last revised February 16, 2018, stated that the responsive behavior prevention and management program shall provide for:
-"Approaches and strategies that are integrated into care, based on the assessed needs of the resident with responsive behavior and co-ordinated and implemented on an interdisciplinary basis."
-"An individualized plan for each resident demonstrating responsive behaviours that includes; behavioural triggers where possible, strategies developed and implemented to respond to behaviours where possible, and actions taken to respond to the resident needs, including assessments, reassessment and interventions and that resident response to interventions is documented."
-"Registered staff will ensure that all residents are assessed and screened for responsive behavior risk on admission, quarterly and with significant change in condition through completion of RAI-MDS."
-"Will ensure that in addition a resident exhibiting a responsive behavior has initiation of PIECES assessment on PCC as indicated, when interventions have not been effective to address responsive behaviours, and has an evaluation of prevention strategies completed at least quarterly and documented in the appropriate RAP or in the progress notes."

The homes policy titled "Responsive Behavour – Prevention or Control" last revised March 14, 2016, stated that "all residents are assessed and an individual Plan of Care is developed to ensure staff are aware of triggers which may and can escalate to responsive behaviours potential for injury".

A review of the resident's electronic and physical medical record did not show documentation of any completed behavioural assessments.

On a specific date, the DOC stated that behavioural assessments had not been

completed for the resident since they were admitted to the home.

The licensee failed to ensure that, for the resident who demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments and reassessments and that the resident's responses to interventions were documented. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 21st day of December, 2018

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

Original report signed by the inspector.