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
Apr 5, 2019	2019_648741_0005	004902-19	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

AYESHA SARATHY (741), INA REYNOLDS (524)

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): March 25 and 26, 2019

During the course of this inspection, Complaint IL-64734-LO/Log # 004902-19 was inspected related to hygiene and grooming, continence care, nutrition and hydration, and reporting and complaints.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Registered Practical Nurse (RPN), a Cook, the Nutrition Manager, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) also reviewed medical records and plans of care for identified residents, observed a resident and reviewed internal investigation notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **4 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	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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident's plan of care was based on an interdisciplinary assessment of the physical functioning, and the type and level of assistance that was required related to toileting, dressing, and hygiene and grooming.

A complaint was reported to the Ministry of Health and Long Term Care (MOHLTC) regarding personal care needs for an identified resident. The complainant stated that the resident was found by a family member lying in bed with their pants half down and incontinent of urine and feces when they arrived at the home for a visit. The complainant also stated that the resident's nails were not cut and hair had not been combed for a long time.

Review of the identified resident's clinical record showed that the resident was dependent on two persons for assistance in using the toilet and one person for assistance with dressing and personal hygiene. It was stated in the clinical record that the resident's needs for physical assistance would be addressed in their care plan, however, there was no evidence that a focus, goals or interventions related to the resident's requirements for physical assistance with toileting, dressing and personal hygiene was documented in their care plan.

In an interview, a Personal Support Worker (PSW) verified that the identified resident

was dependent on staff with personal care needs and required assistance with toileting, dressing and personal hygiene care, and that these guidelines for direct care were not documented in the Kardex and should have been. In another interview, the Director of Care (DOC) acknowledged that the type and level of assistance that was required for toileting, dressing and personal hygiene was not in the plan of care for the identified resident and that the home's expectation was that it should have been.

2. The licensee failed to ensure that an identified resident's plan of care was based on an interdisciplinary assessment of continence, including bladder and bowel elimination.

A complaint was reported to the MOHLTC regarding continence care concerns for an identified resident.

The resident's clinical record was reviewed and showed that they were frequently incontinent of bladder and pads/briefs were used. It was also stated in the Minimum Data Set (MDS) Annual Assessment that the resident's incontinence care needs would be addressed in their care plan, however, there was no evidence of a focus, goals or interventions related to the resident's bladder and incontinence in the care plan or Kardex.

The DOC verified, in an interview, that the resident was incontinent of bladder and bowel and that there were no care plan goals or interventions related to bladder continence strategies and the home's expectation was that there should have been.

3. The licensee failed to ensure that an identified resident's plan of care was based on, at a minimum, interdisciplinary assessment of the resident's sleep patterns and preferences.

A complaint was received by the MOHLTC with concerns related to the identified resident's nutritional status. The complainant stated that the resident regularly missed meals due to sleeping during the day.

A review of the resident's progress notes for a period of five weeks showed several documented notes indicating that the resident displayed behaviours of wandering and staying awake during the night. In an interview, the Nutrition Manager said that the resident has days and nights mixed up and it affects their intake as they miss meals

during the day. In another interview, the Administrator and DOC said that the resident has exhibited behaviour of staying awake at night and sleeping during the day from the time they were admitted to the home.

The resident's care plan and Kardex were reviewed and showed no evidence of a focus, goals or interventions related to resident's sleep and rest pattern.
The Administrator and DOC acknowledged that the resident's sleep and rest patterns were not included in their care plan and should have been.

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 plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1) Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
2) Continence, including bladder and bowel elimination.
3) Sleep patterns and preferences, to be implemented voluntarily.

WN #2: 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 failed to ensure that, for an identified resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to these behaviours, where possible; and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A complaint was received by the MOHLTC with concerns related to an identified resident's personal care. Specifically, the complainant had concerns that the resident's nail care was not being done as the resident was observed by the complainant with long nails.

The resident's Point of Care Tasks were reviewed for Nail Care for a period of nine weeks and showed that the resident was scheduled to have nail care done 14 times within that period of time. It was documented that the resident refused nail care six times, it was not provided five times, and it was completed three times.

A review of the resident's progress notes showed several notes that documented the resident's behaviours related to wandering, restlessness and resistance to personal care. During an interview, a PSW said that the resident may accept or refuse care, particularly related to bathing and nail care, depending on the approach of the staff member providing care. In another interview, a Registered Practical Nurse said that the resident has behaviours of refusing personal care, wandering and restlessness, and that their behaviours should be documented in their care plan.

The resident's care plan, Kardex, assessments and MDS Annual Assessment were reviewed and there was no evidence that any behavioural screening, assessments, identification of behavioural triggers or strategies to prevent, minimize or respond to behaviours had been completed for the resident.

In an interview, the Administrator and DOC acknowledged that strategies, triggers and actions related to responsive behaviours had not been identified or included in the resident's plan of care, and they should have been.

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,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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, to be implemented voluntarily.

WN #3: 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 that an identified resident's written plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the MOHLTC with concerns related to an identified resident's nutritional status. Specifically, the complainant was concerned that the resident was not eating enough as they often missed meals due to sleeping during the day. The complainant also stated that staff were not encouraging resident to eat.

A progress note documented by the physician on a particular date indicated that the resident missed breakfast and lunch that day and had missed both breakfast and lunch for the last week. The note also stated that the resident was sleeping in bed and was arousable but not alert. The resident's nutrition assessment indicated that they were at moderate nutritional risk and had declined in their intake that week with documented intake of one meal and two snacks daily and 66% of required fluid consumption. It was also noted that the resident received a labelled late night snack to support fair intake and complaints of hunger at night.

The resident's care plan was reviewed and indicated that a specified snack was to be provided for the resident with the bedtime snack cart, stored in the servery fridge and offered to the resident as a late night snack if they woke through the night asking for food. The resident's Kardex was also reviewed and there was no evidence of documentation to indicate that a labelled late night snack was to be provided to the resident.

In interviews, the Administrator and DOC said that PSWs in the home did not have access to residents' care plans on Point Click Care and only had access to the Kardex. They said that the labelled late night snack should have been included in resident's Kardex.

WN #4: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for a verbal complaint made to the licensee concerning the care of an identified resident, a response was made to the person who made the complaint, indicating what the licensee did to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

A complaint was received by the MOHLTC with multiple concerns related to an identified resident's personal care and nutritional status. The complainant stated that they lodged the complaint with the Co-Director of Care (Co-DOC) on a particular date. At that time the complainant was informed by the Co-DOC that an investigation would be completed by the home and that they would follow-up with the complainant after the investigation was complete. The complainant stated that there had not been any follow-up by the home regarding their complaint.

A review of resident's progress notes indicated that on a particular date, a complaint was received by the Co-DOC regarding concerns related to the resident's personal care, transfers and nutritional status. It was documented that the Co-DOC informed the complainant that as they were not the resident's Power of Attorney (POA), the POA would be contacted to get approval to proceed. It also stated that the POA said they would take care of the complainant's concerns.

In an interview, the Administrator and DOC were asked whether a response was provided to the complainant regarding the results of the home's investigation for the complaint and they said it had not.

Issued on this 12th day of April, 2019

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

Original report signed by the inspector.