Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2019	2019_834524_0004	019453-19	Complaint

Licensee/Titulaire de permis

Meadow Park (London) Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

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): December 2, 3 and 4, 2019.

The following Complaint intake was completed within the inspection:
Log #019453-19 / IL-70957-LO related to care concerns, food quality, reporting and complaints, and infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nurse Manager/Educator, the Culinary Manager, a Registered Nurse, Personal Support Workers, a Cook, Dietary Aides and residents.

The inspector(s) also observed residents and the care provided to them, resident and staff interactions, observed food production and meal services, reviewed clinical healthcare records, the home's internal complaint records and reviewed relevant policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Food Quality
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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	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. 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 :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure the policy was complied with.

Specifically, staff did not comply with the home's "Point of Service Temperatures" policy with revised date January 19, 2016, which is part of the licensee's Nutrition Care and Hydration Programs.

A complaint was reported to the Ministry of Long-Term Care Infoline on a specific date, regarding a concern that menu items served during meal service were not always served at the appropriate temperatures.

The home's policy titled "Resident Rights, Care and Services – Nutrition Care and Hydration Programs – Point of Service Temperatures" with revised date January 19, 2016, stated: "The Point of Service Temperatures for oral foods and fluids shall be maintained throughout meal and snack service, at:
- a minimum of 64 °C or 147 F for hot foods
- a maximum of 4 °C or 39 F for cold foods.
The Dietary Staff will:
-Record Point of Service temperatures in Celsius of all menu items approximately 5 minutes prior to the commencement of the meal.
-If temperatures do not fall within the acceptable range, initiate corrective action and document on temp sheets and record the re-temp."

A review of the food temperature logs for November 4 to December 3, 2019, showed that food temperatures were not recorded at point of service in the main dining room for the

breakfast menu items on November 29, 2019, and the lunch menu items on December 1, 2019.

A review of the food temperature logs for the period November 4 to December 3, 2019, showed that numerous menu items were not at the acceptable minimum or maximum temperature range for hot and cold foods. No corrective actions or new temperatures were documented.

In an interview, Culinary Manager (CM) #105 confirmed staff documented food temperatures at point of service to verify the temperatures of the food served. CM #105 said the home did not have temperature holding carts to transport food to the dining rooms. CM #105 said that if hot foods are not at the right temperature then staff were expected to bring the food back to the kitchen and put it in the steamer to bring the temperature up to the acceptable range. CM #105 said that holding cold food at the minimum temperatures was a challenge. CM #105 acknowledged that food temperatures were not always taken by staff to verify the actual temperatures of food served and not all temperatures documented fell within the acceptable range.

The licensee has failed to ensure that the home's "Point of Service Temperatures" policy was complied with. [s. 8. (1) (b)]

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 policy, the licensee is required to ensure the policy is complied with, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure any person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

A complaint was reported to the Ministry of Long-Term Care Infoline on a specific date, regarding a concern that improper care was provided to an identified resident resulting in risk of harm to the resident.

The complainant reported that staff had failed to respond promptly to the resident when the resident had health concerns and asked staff for help. The complainant said that on a specific date, the resident called them and stated that they were having specific concerns when it was a shift change. The resident had called for help and a registered nurse said that they would be right there, but they had to wait for a specific period of time. The complainant then said they called the nursing station and when they arrived at the home a registered nurse was just then going into the resident's room.

A clinical record review showed the resident had a specific diagnosis related to their health concern. The progress notes showed that the resident was transferred for medical attention on a specific date.

Record review of the home's "Concern/Complaint Form" binder obtained from Administrator #100, showed a written complaint was received on a specific date, from the resident's family member. The complainant stated that they had received a phone call from the resident. They told the nurse they were having specific health concerns and said they would come back. They "didn't come back until I called the desk."

The complaint was forwarded to the Director of Care (DOC) on the same day. The written complaint form completed by the Director of Care on a later date, stated in the final resolution that, "reminded nurse – resident first – if unable to assist […] ask for assistance."

In an interview, Administrator #100 said that they were aware of the complaint and said that the Director of Care had spoken to a Registered Nurse. Administrator #100 said there should have been a timely response to resident #001's complaint of health concerns and acknowledged the resident was placed at risk of harm. Administrator #100 said the home should have immediately investigated the incident and notified the Director of the alleged improper care to the identified resident.

The licensee has failed to ensure that an allegation of improper care of an identified resident that resulted in harm or risk of harm was immediately reported to the Director. [s. 24. (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 any person who has reasonable grounds to suspect that any of the following has occurred or may have occurred shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

Issued on this 10th day of December, 2019

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

Original report signed by the inspector.