Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 21, 2021	2021_790730_0043	015015-21, 015825-21	Critical Incident System

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

CHRISTINA LEGOUFFE (730), JULIE LAMPMAN (522)

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 13, 14, 15, and 16, 2021.

The following Critical Incident Systems (CIS) intakes were completed within this inspection:

CI #2643-000009-21/ Log #015015-21 related to falls prevention and management
CI #2643-000010-21/ Log #015825-21 related to a missing narcotic

An Infection Prevention and Control (IPAC) inspection was also completed within this inspection.

Inspector #731 Kristen Murray was also present during this inspection.

This inspection was completed concurrently with complaint inspection #2021_790730_0044.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Care (ADOCs), a Staff Educator, a Silver Fox Pharmacy Liaison, Housekeepers, a Screener, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The inspector(s) also completed an observed residents and the care provided to them, observed IPAC procedures in the home, and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.

2 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	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 the home's "Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" policy was complied with for two residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policies and procedures ""Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program," last revised May 2019. The falls prevention program required staff to mechanically lift a resident after a fall if no fracture of the lower extremities was suspected, and if the resident was unable to independently get to a standing position. The program also required staff to initiate a Head Injury Routine (HIR) when a resident sustained an unwitnessed fall.

On two dates a resident sustained unwitnessed falls and HIRs were initiated. On some occasions the resident was documented as sleeping or in the dining room and the assessments were not completed.

On another date the resident sustained an unwitnessed fall. Clinical records indicated

that staff assisted the resident to their feet without the use of a mechanical lift.

A Registered Nurse (RN) said that the HIRs for the resident, did not meet the expectations of the home. They said that the resident should have been woken up to complete assessments and that HIR assessments could also have been completed when the resident was in the dining room. The RN also said that when the resident fell, staff should have used the mechanical lift to assist the resident off the floor. [s. 8. (1)]

2. A second resident sustained two unwitnessed fall and HIRs were initiated. On various occasions it was documented that the resident was sleeping or visiting with family and the assessment was not completed.

The Director of Care (DOC) said that the HIRs for the two residents, were not completed as per their expectations. They said that all checks should have been completed unless the resident refused.

The homes failure to complete the Head Injury Routines for the two residents, and not using the mechanical lift to get one resident off the floor after a fall as per policy placed the residents at risk for harm.

Sources: Resident Rights, Care and Services- Required Programs- Falls Prevention and Management- Program" (Revised May 2019), clinical records for two residents including progress notes and head injury routine documentation; and interviews with an RN and other staff. [s. 8. (1)]

3. The licensee has failed to ensure that the home's medication incident policy was complied with.

O. Reg 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Review of Silver Fox Pharmacy Medication Incident policy 1.5 indicated Silver Fox Pharmacy provided both electronic and paper-based incident reporting tools. For medication incidents that originated in the home the incident report was to be filed by the home.

Review of a Critical Incident System (CIS) report noted a narcotic was delivered by pharmacy and signed as received by the home. On a later date, it was noted that the narcotic could not be located in the home.

In an interview, a Registered Practical Nurse (RPN) stated registered staff should complete a medication incident report for missing narcotics.

In an interview, the Director of Care (DOC) stated a medication incident report had not been completed for the missing narcotic as registered staff thought the narcotic had been delivered. The DOC stated it wasn't until a later date, they realized that the narcotic was actually missing, and the investigation was initiated and the incident report was missed. The DOC stated a medication incident report should have been completed for the missing narcotic.

Sources: CIS report, Silver Fox Pharmacy Medication Incident policy 1.5 with a revision date of March 2020, and interviews with the DOC, RPN and other staff. [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 the home's falls prevention and management and medication incident policies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the outcome or current status of a resident after an incident that caused an injury to the resident and resulted in a transfer to hospital and a significant change in the resident's health condition.

The home submitted a Critical Incident Systems (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident where a resident fell and was transferred to hospital. The CIS report was not amended to indicate the outcome or current status of the resident.

The Administrator said that the CIS report should have been updated to indicate the current status of the resident.

Sources: Resident clinical record, CIS report, and an interview with the Administrator. [s. 107. (4) 3. v.]

Issued on this 21st day of December, 2021

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

Original report signed by the inspector.