Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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Original Public Report

Report Issue Date: June 15, 2023	
Inspection Number: 2023-1151-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Meadow Park (London) Inc.	
Long Term Care Home and City: Meadow Park (London), London	
Lead Inspector Rhonda Kukoly (213)	**Inspector Digital Signature** Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2023.06.15 16:17:53 -04'00'
Additional Inspector(s) Brandy MacEachern (000752) Leah Carrier (000748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5, 6, 7, 2023

The following intake(s) were inspected:

- Intake: #00085549, Critical Incident #2643-000010-23, related to a fall
- Intake: #00086479, Complainant related to care concerns
- Intake: #00086696, Critical Incident #2643-000014-23, related to care concerns
- Intake: #00087899, Critical Incident #2643-000015-23, related to a missing resident

The following intakes were completed in this inspection:

- Intake: #00083994, Critical Incident #2643-000006-23, related to a fall
- Intake: #00021034, Critical Incident #2643-000003-23, related to a fall
- Intake: #00088395, Critical Incident #2643-000016-23, related to a fall
- Intake: #00089099, Critical Incident #2643-000017-23, related to a fall

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care provided clear direction to the staff and others who provided direct care to the resident.

Rational and Summary
A resident had specific directions related to a treatment that were based on regular testing and adjustment of the treatment based on the results of the test. The care plan did not provide any details regarding the adjustment and there was nothing in the kardex related to the treatment at all. The resident was observed with the treatment in use, but not as per the order. There was risk to the resident when there was not clear direction for staff related to the treatment, the treatment was not provided as ordered, and the test results were lower than the level recommended by the physician.

Sources: Staff interviews, health records and observation for a resident. [000752]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had a fall, they were assessed, and a post-fall assessment conducted.

Rational and Summary
The home reported to the Director that a resident had an unwitnessed fall. A post-fall assessment, including head injury routine, was not completed until four days after the fall, after the resident had a subsequent fall. There was risk that injury, including head injury, was not identified and therefore appropriate treatment not provided when a resident was not assessed after a fall.

Sources: A critical Incident report, health records for a resident, the home's internal investigation records and staff interviews. [000748]