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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 10, 2024
Inspection Number: 2024-1151-0002
Inspection Type: Complaint Critical Incident
Licensee: Meadow Park (London) Inc.
Long Term Care Home and City: Meadow Park (London), London

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.07.10 13:23:55 -04'00'

Additional Inspector(s)
Neelam Patel (000814)
Dante De Benedictis (000818)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 18, 20, 21, 24, 25, 2024

The following intake(s) were inspected:

- Intake: #00114219, Critical Incident related to alleged staff to resident abuse.
- Intake: #00114353, Critical Incident related to an environmental hazard.
- Intake: #00114486, Complaint related to resident care concerns.
- Intake: #00115002, Critical Incident related to resident neglect.
- Intake: #00115232, Critical incident related to improper/incompetent care of a resident.

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

Continence Care
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Investigation in Response to Alleged Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

The licensee has failed to ensure that an alleged incident of staff to resident neglect that was reported to the licensee was immediately investigated.

Rationale and Summary:
The home received a written complaint that expressed concerns of resident neglect.

In an interview the Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed receiving a letter with allegations of resident neglect. They said the concerns were discussed at a weekly huddle, however an investigation was not initiated or completed. There was no written evidence of an investigation ever being completed.

There was risk to the resident as they were left susceptible to alleged neglect when an investigation was not initiated.

Sources: Staff interview, Record review. [000818]

WRITTEN NOTIFICATION: Reporting

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee has failed to ensure that when a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rational and Summary:

The home submitted a Critical Incident System (CIS) Report related to allegations of staff to resident neglect. The CIS indicated that the resident had not been properly attended to or assisted with their night care.

In an interview a Registered Practical Nurse (RPN) said they were informed on the day shift that the resident may have not been provided any care on the previous night shift. The RPN considered this to be neglect and improper care of the resident and reported the incident immediately to the ADOC.

In an interview The ADOC confirmed the were made aware of the incident, but they forgot to follow up on the incident on that day and did not report the incident immediately.

In an interview The DOC said the allegations were not reported immediately by the ADOC, and said the expectation was for any allegations of neglect or improper care to be reported immediately.

Sources: record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Reporting

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee had failed to ensure that when the home received a complaint letter related to allegations of resident's neglect, a copy of the complaint was submitted to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

Rationale and Summary:
The Ministry of Long-Term Care received a complaint stating the complainant submitted a letter of complaint to the home and received no response.

A written complaint was received by the home from a complainant that expressed concerns of resident neglect.

In an interview the DOC and ADOC confirmed receiving a letter with allegations of resident neglect. They said a copy of the complaint was not submitted to the Director.

There was risk to the resident as they were left susceptible to alleged neglect by failing to notify the Director of the written complaint.

Source: Staff interview, Record review. [000818]

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
A) Conduct daily audits for the care provided to three identified residents to ensure their care is provided as per their plan of care.

B) Audits are to be completed for each of the three residents for a minimum period of four weeks.

C) Keep written records of the audits including the names of the residents that were audited, the dates and times of the audits, who completed the audits and any corrective action taken if any concerns identified.

Grounds
The licensee has failed to ensure the care set out in the plan of care was provided to three identified residents as specified in their plans.

Rational and Summary:
A) The home submitted a Critical Incident System (CIS) Report related to allegations of staff to resident neglect. The CIS indicated that the resident had not been properly attended to or assisted with their night care.

A review of the resident's plan of care showed specific interventions related to their night care routine and toileting routine and assistance required.

In interviews two PSWs said they did not provide care to the resident on their specific assigned evening and night shift.

In an interview the Administrator and DOC said staff did not check on the resident and provide the required assistance as per the plan of care at bedtime and through out the night on a specific date. They said it was the expectation that staff provide care to the resident as specified in their plan of care.

The resident was put a risk when staff did not check on the resident or provide care to the resident at bedtime and through the night on a specific date.

Sources: record reviews and staff interviews. [523]

B) The Ministry of Long-Term Care received a complaint regarding specific resident care concerns. As per the resident's care plan specific interventions were to be completed at designated times. An observation of the resident during the inspection showed those interventions were not completed at the designated times.

In an interview a PSW acknowledged the interventions were not completed at the designated times.

There was risk to the resident when the specific interventions were not completed.

Sources: Care Plan, observation, interview. [000818]

C) The Ministry of Long-Term Care received a Critical Incident Report (CIS) related to alleged staff to resident abuse.

It was identified in the resident's plan of care that multiple staff members to provide all aspects of care to the resident.

The Internal investigation report indicates a PSW provided care to the resident on

their own despite knowing the specific intervention.

The DOC acknowledged the PSW did not provide the care to the resident as specific in their plan of care.

By not following the care plan the home failed to provide care to the resident as set out in their plan of care. There was a risk of not meeting resident care needs as planned.

Sources: Review of resident clinical records, internal investigation notes and interview with DOC. [000814].

This order must be complied with by August 9, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.