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: October 25, 2024
Inspection Number: 2024-1151-0004
Inspection Type: Critical Incident
Licensee: Meadow Park (London) Inc.
Long Term Care Home and City: Meadow Park (London), London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9, 10, 11, 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00124546 - 2643-000065-24 related to continence care.
- Intake: #00124857 - IL-0130311-AH/2643-000069-24 related to alleged neglect.
- Intake: #00125939 - 2643-000074-24 related to Infection Prevention and Control.
- Intake: #00126148 - IL-0130896-AH/2643-000076-24 related to the fall of a resident.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Unclear Care Plan Direction

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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,

(c) clear directions to staff and others who provide direct care to the resident;

The licensee failed to provide clear direction in the resident's Care Plan with respect to repositioning.

Summary and Rationale:

The home submitted a Critical Incident System (CIS) Report related to possible staff to resident neglect. The CIS indicated that through the home's investigation, it was determined that, repositioning of a resident did not take place as indicated in the Care Plan.

During an observation, the resident was not turned or repositioned as documented in their Care Plan. When this was brought to the attention of the home's staff, it was explained that repositioning was to take place "as needed only."

A review of the resident's Care Plan revealed instruction to turn and reposition the resident every two hours without condition. This statement was repeated in the resident's Kardex. Additionally, there was also another entry in the Kardex appearing alongside the previous one that stated “as needed.” The second entry introduced a

condition contradicting the imperative direction of the first, rendering care direction for the resident unclear.

In interviews completed with the Administrator and a Personal Support Worker (PSW), both stated that repositioning was to take place with the resident as needed only. Both acknowledged that the direction provided to staff in the Care Plan was unclear.

There was a risk to the resident when care directions were not clearly communicated in their Care Plan and Kardex, albeit at a low level.

Sources: observation, record reviews and staff interviews.

WRITTEN NOTIFICATION: Plan of care based on assessment of resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that the care set out in the plan of care for the resident was based on an assessment of the resident related to the use of a Personal Assistive Services Device (PASD).

Rationale and Summary:

A review of the home's, "LTC Personal Assistive Services Devices (PASDs)" policy indicated prior to the introduction of PASD with restraining qualities, an

interprofessional PASD/Restraint assessment would be completed for in Point Click Care (PCC).

Upon review of the resident's clinical records, it was identified that they had initiated use of a PASD after their fall. The resident's clinical records show no assessment being completed before a PASD was considered or prior to the application of a PASD.

A PSW stated they have been using the PASD when required. They also noted that the Point of Care (POC) task must be documented for the use of the PASD.

The Restorative Care Coordinator verified that the PASD/Restraint assessment in PCC was not completed for the resident prior to implementing the PASD.

Sources:
Resident's clinical record review and staff interviews.

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee has failed to ensure the use of the Personal Assistive Services Devices (PASD) has been consented to by the substitute decision-maker (SDM) of the resident.

Rationale and Summary:

A review of the resident's clinical records, identified that they had initiated the use of a PASD. The resident's clinical records and clinical file show no consent being obtained from the SDM before a PASD was considered.

A review of the home's, "LTC Personal Assistive Services Devices (PASDs)" policy indicated prior to the introduction of PASD with restraining qualities, the Registrant/Restorative Care Coordinator/designate would meet with the resident and /or SDM to obtain informed consent and had them sign the "Consent to the Use of Personal Assistive Devices (PASD) form."

The Restorative Care Coordinator acknowledged that the Consent from the resident's SDM was not obtained before a PASD was considered or prior to the application of a PASD.

Sources:
Resident's clinical record review and staff interviews.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

A) Indicated staff members should receive retraining on the home's Infection Prevention and Control (IPAC) Program including hand hygiene, and donning and doffing PPE. The training must be documented including the content, the date, and the name of the trainer.
B) Conduct at least two audits on each of the three staff to ensure they followed hand hygiene, PPE donning and doffing policies. A documented record must be maintained of these audits, including the date the audits were completed and any corrective actions taken.

Grounds

The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with the IPAC Standard for Long-Term Care Homes.

Rationale and Summary:

The IPAC Standard for Long-Term Care Homes (LTCHs) indicated under section 9.1 (b) routine practice shall include hand hygiene, including but not limited to at the four moments of hand hygiene and section 9.1 (d) the licensee should ensure that Additional Precautions include the proper use of PPE, including the appropriate selection, application, removal, and disposal.

Three staff members were observed to provide care and/or services to residents who were under additional precautions without performing application and/or removal of the proper PPE as per proper IPAC procedures.

During an interview with IPAC Lead, they stated that the staff had not followed procedures in line with the expectations and protocols. IPAC Lead acknowledged that staff should have followed IPAC procedure each time they entered a resident's room who was on additional precautions or provided care.

There was a risk of spreading healthcare-associated infections when staff did not follow additional IPAC precautions.

Sources:
IPAC observations of the home, review of the home's "LTC Hand Hygiene Policy and LTC hand hygiene program" and "LTC Routine Practices policy", interviews with staff, IPAC Lead and Interim IPAC coverage RN.

This order must be complied with by November 22, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTE 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.