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

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Public Report

Report Issue Date: December 16, 2024
Inspection Number: 2024-1151-0005
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): December 4, 6, 9, 2024
The inspection occurred offsite on the following date(s): December 5, 2024
The following intake(s) were inspected:
Intake#

- 00129333: -related to alleged resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2. Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that written strategies were developed for a resident who was demonstrating responsive behaviours related to a known trigger.

A Critical Incident System (CIS) report was submitted for allegations of resident to resident abuse related to the responsive behaviours of a resident. The resident was known to have responsive behaviours. During multiple staff interviews, staff all indicated knowledge of a specific known trigger for responsive behaviours of the resident. None of the staff interviewed were able to show written strategies to prevent, minimize or respond to the responsive behaviours of the resident, specific to that trigger. Two staff indicated interventions should be in the care plan; that is included both in point click care and in the one to one support binder. Review of the resident's plan of care and the one-to-one support staff binder did not find interventions related to responsive behaviours from that known trigger.

Sources: A resident's plan of care, Review of the LTC Responsive Behaviour Program (revised 14/08/2024) and staff interviews.

WRITTEN NOTIFICATION: Plan of Care

NC # 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 plan of care for a resident for agency staff to know about the a LTC policy and what to do if the resident was not following their letter of understanding.

Some staff were not provided with clear direction on the LTCH's Policy and the Letter of Understanding. The Letter of understanding was not kept in a resident's paper chart nor on the resident's home unit, but rather in locked file in Resident Family Service Coordinator's office. On page two of "The Letter of Understanding" includes rules not consistently enforced.

There were no clear directions in a resident's plan of care related to the home's rules and regulations related to the Letter of Understanding signed by residents. One-to-one staff were observed not enforcing a rule only to be followed also by an observation of the responsive behaviour when the administrator attempted to enforce that rule.

As the plan of care did not provide clear direction for one-to-one staff, to know their role and the interventions related to promoting a resident's compliance with the rules and regulations of the home, there would be increased risk of responsive behaviours, directed towards other residents and staff, by that resident.

Sources: Interviews with staff, observations and Critical Incident System report, Letter of Understanding.