Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2013	2013_303563_0006	L-000941-13	Critical Incident System

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

Long-Term Care Home/Foyer de soins de longue durée

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELANIE NORTHEY (563)

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 2, 2013

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, the Resident Assessment Instrument (RAI) Coordinator, and two Health Care Aides.

During the course of the inspection, the inspector(s) made observations, reviewed health records, policies, education and training records and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.
a) A review of the resident's plan of care revealed behavioural triggers, and strategies developed or implemented to respond to the resident's behaviours were absent and there was no record of an assessment or reassessment of the resident's needs. Management confirmed there should be a behaviour and mood assessment completed in the Resident Assessment Protocols (RAPs) and this was not done. Management confirmed a PIECES Assessment was started and was not completed and should have been.
b) The plan of care did not include behavioural triggers as identified in the MDS assessment. No documentation in the care plan existed regarding strategies to respond to these identified behaviours.
c) Two health care aides (HCA) confirmed interventions to respond to the needs of the resident were absent in the plan of care. HCAs confirmed the Kardex is where HCAs look for care instructions and there were none listed to address the resident's responsive behaviours.
d) The progress notes at the time of admission revealed escalating behaviours as documented in Point of Care (POC) by the HCAs. No reassessment was completed when the resident's behaviours increased. [s. 53. (4)]

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The Licensee failed to ensure that the following device to limit movement was not used in the home: sheets, used other than for a therapeutic purpose.
a) Two Health care aides (HCA) confirmed a bed sheet was applied around the resident's waist like a belt and around the chair and tied in a loose knot.
b) Two HCA confirmed the resident would not be able to remove the tied sheet or stand up. [s. 112. 7.]

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 following device is not used in the home: sheets, used other than for a therapeutic purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that a 24 hour admission care plan identified the following with respect to the resident: any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

Management confirmed the 24 hour Plan of Care on admission should have identified the behaviours under the "other" section of the paper form as described in the progress notes on the day of admission. Potential behavioural triggers and safety measures to mitigate those risks were not identified. [s. 24. (2) 2.]

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Issued on this 12th day of December, 2013

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

Melanie Northey