



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Jan 27, 2014, 2014_217137_0003, L-001050-13, Complaint

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

MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 24, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Co-Director of Care, 2 Registered Nurses, 2 Registered Practical Nurses and 2 Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed internal medication incident report and internal investigative reports and relevant policies and procedures.

The following Inspection Protocols were used during this inspection: Medication



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131.
Administration of drugs**

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :



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1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse as evidenced by:

Medications, for an identified resident, were left unattended by a registered staff member and administration was delegated to an unregulated health care provider.

As per the home's policy, Residents' Rights, Care and Services - Medication Management - Administration of Medications - October 21, 2013, all medications shall be administered only by those authorized under the Regulated Health Professionals Act and their respective regulatory colleges including the Attending Physician or Registered Nurse or Registered Practical Nurse in good standing with the College of Nurses of Ontario and the Registrant will remain in attendance until the medication is taken.

The Director and Co-Director of Care both confirmed that medications, for an identified resident, were left unattended by a registered staff member and administration was delegated to an unregulated health care provider. Both confirmed that the expectation is that medications are not to be left unattended and administration not be delegated to an unregulated health care provider.

[s. 131. (3)]

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions



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Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider as evidenced by:

There is no documented evidence that the Power Of Attorney (POA) was notified of the medication incident and the Director of Care and Co-Director of Care both confirmed that the home did not notify the POA of the medication incident. [s. 135. (1) (b)]

Issued on this 28th day of January, 2014

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

Marian C. Mac Donald