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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2018	2018_538144_0039	024372-17, 016568-18, 017708-18, 029538-18	Critical Incident System

Licensee/Titulaire de permis

Meadow Park (Chatham) Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Meadow Park Nursing Home (Chatham)
110 Sandys Street CHATHAM ON N7L 4X3

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

CAROLEE MILLINER (144), ALICIA MARLATT (590)

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 4, 5, 6, 2018.

The following intakes and critical incident (CI) reports were completed during the inspection:
016568-18, CI 2685-000005-18 related to responsive behaviours, altercations and other interactions
017708-18, CI 2685-000006-18 related to altercations and other interactions
029538-18, CI 2685-000008-18 related to plan of care
024372-17, CI 2685-000011-17 related to prevention of abuse and neglect.

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

During the course of the inspection, the inspector(s) reviewed seven resident clinical records and relevant home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

One critical incident (CI) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) included an incident of abuse or neglect involving one resident.

Review of the documentation on the CI report showed that one Personal Support Worker (PSW) told another PSW that they had taken away one residents' call bell and removed the batteries from their bed and chair alarms so they wouldn't ring again.

Three PSW's working the night of the incident were interviewed during the homes internal investigation and during the interviews, said they had provided the resident with their call bell alarms immediately after the batteries had been removed by the above PSW.

The three PSW's were not available for interview by the inspector during the inspection.

Review of the homes' policy titled "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect", version 2, last revised on 2017-06-02 defined neglect as 'the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

The policy further included that "Staff members, volunteers, substitute decision-makers, family members or any other person who has reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager is on site at the Home."

On interview with the inspector, two PSW's shared that removing a residents' call bell or alarms was inappropriate and that resident behaviours should be immediately reported to their supervisor. Both PSW's shared that call bells and alarms were the residents method of communicating to staff that they needed help, and they should always have their call bells and alarms accessible to them for safety reasons.

The DOC shared that they had completed an internal investigation and that the PSW that removed the call bells and alarm had resigned their position when questioned by the homes management team about the incident.

The DOC shared that they had reported the incident to the MOHLTC on the day they heard about the incident.

The DOC stated that the PSW's had not reported the incident to the charge nurse during the shift it occurred on, so the charge nurse was not aware of the situation to report it to the management team.

The PSW's had reported the incident to the charge nurse that usually worked the night shift on that unit, however this was several days after the events occurred.

The DOC said that the PSW's should have reported the incident to their supervising nurse immediately as outlined by the homes abuse policy. [s. 20. (1)]

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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of one CI revealed that a resident experienced a fall that resulted in an injury.

During review of the clinical record for the resident that experienced the fall, a skin and wound assessment could not be located related to the injury sustained during the fall.

Two progress notes included that the resident had a fall that resulted in impaired skin integrity.

One RN and one RPN told the inspector that it was the responsibility of registered staff to complete a skin and wound assessment for a resident as soon as an area of impaired skin integrity or a wound occurred.

The RN and RPN both advised the inspector that skin and wound assessments are completed on the Point Click Care (PCC) skin and wound assessment template.

The Director of Care (DOC) and Administrator reviewed the clinical record for the resident and concurred with the inspector that a skin and wound assessment had not been completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment in response to the injury sustained during the fall. [s. 50. (2) (b) (i)]

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 ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.