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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 11, 2015	2015_398605_0013	T-001681-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 OVERLEA BLVD TORONTO ON M4H 1P4

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

ISABEL AND ARTHUR MEIGHEN MANOR
155 MILLWOOD ROAD TORONTO ON M4S 1J6

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

SARAH KENNEDY (605), STELLA NG (507), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 22, 24, 27, 28, 29, 30, May 1, 4, 5, 6, 7, 8 and 11, 2015.

The following complaint intakes were inspected concurrently: T-1044-14 and T-1857 -15.
The following critical incident intake was inspected concurrently: T-2052-15.
The following follow-up intake was inspected concurrently: T-1922-15.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant director of care (ADOC), facility and environmental services manager (ESM), food services manager (FSM), registered dietitian (RD), registered nursing staff, personal support workers (PSWs), dietary aides, housekeepers, recreation and volunteer coordinator, administrative assistant, residents, family members and substitute decision makers.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
5 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2014_357101_0057	605

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with order CO#001, originally issued May 9, 2014, during the 2014 RQI #2014_321501_0003, with an order compliance date of June 30, 2014. The order directed the home to ensure residents did not have access to non-residential areas when unattended by staff (i.e. unit serveries, dish wash areas and service elevators).

This order was followed-up on January 26, 2015, and was still not in compliance. Therefore, the order was re-issued with inspection #2014_357101_0057 with an order compliance date of February 27, 2015. The re-issued order required the licensee to prepare, submit and implement a plan to ensure that all doors in resident home areas that lead to non-residential areas, including, but not limited to, serveries with hot holding areas, and a dish wash area with access to the service elevator, are kept closed and locked when unattended by staff to restrict resident access. The plan shall include: immediate actions to ensure the 2E servery is restricted to residents when unattended by staff as this door could not be locked at the time of inspection, immediate short-term and long-term actions taken to ensure access to all serveries in the home are restricted to residents when unattended by staff. The licensee submitted the plan to inspector #101.

On April 22, 2015, at the commencement of this inspection (RQI #2015_398605-0013), the licensee failed to comply with the order issued twice before. [s. 5.]

2. The licensee has failed to ensure that the home's environment is kept safe and secure for its residents.

Observations on April 22, 2015, at 11:05 a.m., revealed that the door from the dining room to the servery on the third floor (Lawrence unit) was unlocked and ajar. Located in the servery was a coffee maker, an oven, and warming tables. The warming tables were on and hot under the stainless steel covers. A pocket door from the servery to the dish washing area was closed and locked. One resident was observed sitting at a table in the dining room. No staff were present in the area at the time. An identified registered staff member summoned to the area confirmed that the servery door should be locked when not supervised. (178)

3. Observations on Friday April 24, 2015, at 3:30 p.m., revealed that the door to the servery on the second floor (Coombs unit), a secure unit, was not locked. Located inside the servery was an oven, warming tables, and a hot water dispenser. The pocket door from the servery to the dishwashing area was closed, but not locked. Located inside the dish washing area was a commercial dishwasher and a service elevator with a key in the lock. No staff were in the servery or dish washing area at the time. No residents were in the dining room or servery area at the time. Interview with an identified registered staff member summoned to the area confirmed that the door to the servery was not locked and stated that the door should have been locked because a resident could be harmed. The identified registered staff member had to slam the servery door forcefully three times

in order to engage the lock. The identified staff member confirmed that the unit is home to a number of cognitively impaired residents, some of whom wander. At 3:40 p.m., an identified dietary aide entered the servery having returned from a break. The identified dietary aide stated that the doors to the servery and the dish washing area were not locked because the locks were not functioning properly, the locks had been repaired unsuccessfully in the past, and that management and maintenance staff were aware that the locks are not functioning properly. (178)

4. On May 5, 2015, the second floor (Coombs unit) servery door was found open and unlocked. Staff were not present at this time. Further observation revealed that there was a sharp knife in a drawer. Interview with an identified staff member confirmed that the servery door was left open and the lock was not functioning. (605)

5. On May 5, 2015, the third floor (Fisher unit) servery door was found open and unlocked. Staff were not present at this time. Interview with an identified staff member confirmed that there was a sharp knife stored in one of the servery drawers. Further inspection revealed that the servery door lock had fallen off the door and was placed on the counter. (605)

An interview with the Executive Director (ED) confirmed that the serveries and dish washing areas should be secured and locked and that the servery doors and locks which are presently in place are not sufficient. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Staff interviews and review of progress notes revealed that when resident #005 returned to the home after being hospitalized, the resident had an identified wound. Measures were taken to cushion the wound, but a few days later, the skin had started to break down further.

Record review and interview with the home's Registered Dietitian (RD) confirmed that she received a referral to assess the resident after return from hospital, and assessed the resident on an identified date when the resident returned to the home. The RD confirmed that she received another referral a few days after the resident returned from hospital, to assess the resident related to poor intake, and did so the following day after receiving the referral. The RD revealed that she was not made aware of the resident's impaired skin integrity on either occasion, and did not consider the impaired skin integrity when making recommendations for the resident. The RD stated that she became aware of the resident's impaired skin integrity on an identified date in 2015, when she received a referral related to the resident's wound which had progressed to a more advanced pressure ulcer.

Interview with the Director of Care (DOC) confirmed that it is the home's policy to refer all residents with impaired skin integrity to the RD, and the registered staff should have informed the RD of the residents wound. [s. 6. (4) (a)]

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 staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, are equipped with locks to restrict unsupervised access to those areas by residents.

Observation on April 22, 2015, revealed that the door leading from the inside lobby to the main floor outside terrace was not locked allowing anyone access to the secure terrace area. However, the door was locked from the outside, preventing access from the terrace into the home, meaning that if a resident wandered out into the garden through the unlocked door, the resident would not be able to get back into the home because the door was locked, potentially trapping the resident in the secure terrace area.

An interview with the ED on April 24, 2015, confirmed that the terrace door could not be locked from the inside but has an alarm which is activated when the door is open to alert staff when someone opens the door. The alarm rings on the third floor (Lawrence unit), and staff on that unit notify the receptionist that someone has opened the door. The ED revealed that arrangements had been made to have a locksmith attend the home to ensure that the door to the terrace could be locked.

Observations on April 27, 2015, confirmed that the door leading from the lobby to the main floor terrace was equipped with a lock to restrict unsupervised access to the area by residents and was locked at that time. [s. 9. (1) 1.1.]

2. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Observations on April 22, 2015, revealed that the doors leading from the activity rooms onto the balconies on the third floor (Lawrence unit) and the fourth floor (Dinnick and Moore units) were not locked. No staff were present in any of the areas at the time. One resident was observed using a computer in the activity room on Moore unit.

Interviews with identified registered staff on Lawrence unit and Dinnick unit revealed that the registered staff were unsure whether the doors to the balconies should be locked during the day when not supervised. Interview with the home's ED revealed that it is the home's process to open the balcony doors in the morning in pleasant weather, and leave them open until the evening when they are locked by the evening registered nurse.

Review of the home's policy "Door Alarms, policy #6.15", revised April 2015, indicated

that all risk areas of the home, including balconies, need to be secured by 9 pm every night as per the RN checklist. The home did not have a written policy in place regarding when doors leading to balconies need to be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Interview with the ED on April 24, 2015, revealed that the home's practice was that residents' access to the balconies on the third and fourth floors may be unsupervised during the day in warm weather. The ED confirmed that the home's written policy did not outline when doors leading to secure outside areas should be locked to permit or restrict unsupervised access to those areas by residents.

The home's policy was revised to indicate that all doors leading to the outside of the home must be kept closed and locked at all times, and that residents accessing restricted outdoor areas, including balconies, are to be supervised.

Observations on the afternoon of May 1, 2015, confirmed that the balcony doors on all units were locked. [s. 9. (2)]

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 all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment kept clean and sanitary.

i. On April 22, 2015, it was observed that resident #010's wheelchair was soiled with crumbs and dust. On April 24, 2015, it was observed that resident #006's wheelchair was soiled with white crumbs. On April 27, 2015, it was observed that resident #004's wheelchair had white debris on the seat cushion and white streaks on the wheels.

On May 1, 2015, it was confirmed by identified PSWs that all of the above ambulatory equipment remained soiled. In addition, resident #004's wheelchair had dried food collecting in the corners of the chair.

An interview with an identified registered staff member revealed that it is the responsibility of the night PSWs to clean ambulatory equipment according to a wheelchair cleaning schedule on each unit. Review of the cleaning schedules revealed that equipment is routinely cleaned on a monthly basis.

An interview with another identified registered staff member revealed that the expectation is for PSWs to clean the wheelchairs as per the schedule, and to clean the equipment as needed if found soiled. It was confirmed that the equipment for the identified residents was not kept clean and sanitary.

ii. On April 22, 2015, a wall in an identified dining area was observed to be soiled with dried food and dirty dish water stains. On May 1, 2015, at 2:45p.m., the area remained unclean.

An interview with an identified housekeeper confirmed that the wall was stained and soiled.

An interview with the Facility and Environmental Services Manager (ESM) confirmed that the expectation is for the wall to be cleaned whenever it is soiled and that the home was not kept clean and sanitary.

iii. On May 5, 2015, the following observations were made in the main kitchen and in the serveries on the identified units:

Main kitchen:
- dust and water stains on the ceiling

Second floor, Coombs unit servery:
- dried food build-up underneath the microwave
- mold on the ceiling and upper cupboards

Second floor, Davis unit servery:
- dirt on the baseboards and floor
- dust on the ceiling
- stickiness on a drawer and the cupboard doors

Third floor, Lawrence unit servery:
- water stain and mildew odour underneath the sink
- dried food underneath the microwave
- stickiness on drawers and cupboard doors

Third floor, Fisher unit servery:
- water stains on the cupboard doors
- water stains and mold underneath the sink
- unclean floor and baseboards

Fourth floor, Dinnick unit servery:
- dried food underneath the microwave
- water stains on the cupboard fronts
- stickiness on cupboard doors
- unclean baseboards

Fourth floor, Moore unit servery:
- stickiness on cupboard doors

Interview with the ESM confirmed that the above mentioned areas in the home were unclean and unsanitary and the expectation is for the home to be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home is maintained in a good state of repair.

On April 22, 2015, the following observations on the identified units were made:

Second floor, Davis unit:
- water leaking from the ceiling in the spa room above the tub
- loose grab bar in the resident/visitor washroom

Fourth floor, Moore unit:
- loose handrail outside the resident/visitor washroom

Third and fourth floor dining areas:
- floors are scratched

On May 5, 2015, the following observations were made in the serveries on the identified units:

Second floor, Coombs unit servery:
- water dripping from the wood underneath the steam table
- tile behind the steam table is missing grout and dislodged from the wall
- two cupboard doors fell off when opened

Second floor, Davis unit servery:
- water damage to the wood underneath the steam table (wet to touch)
- 2 missing cupboard doors
- multiple loose door hinges on cupboard doors

Third floor, Lawrence unit servery:
- multiple cupboard doors misaligned

Third floor, Fisher unit servery:

- water dripping from the wood underneath the the steam table (dripping into trays)

Fourth floor, Dinnick unit servery:
- water leaking from the ice machine (soaking wet sheets are on the floor collecting the water)

The above observations were confirmed by the ESM who stated that the expectation is for the home to be maintained in a good state of repair. [s. 15. (2) (c)]

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 home, its furnishings and equipment are kept clean and sanitary and that the home is maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be used by residents and staff at all times.

i. Observations on April 22, 2015, revealed the call bells in both the resident/visitor washrooms on third floor Lawrence and Fisher units were not functioning.

Interviews with identified PSWs confirmed that the identified call bells were not functioning.

An interview with the ESM confirmed that the identified call bells were not functioning and the expectation is that the staff-communication and response system functions so it can be used by staff and residents at all times.

ii. On April 22, 2015, at 3:13p.m., the call bell in resident #010's bathroom was wrapped around a grab bar and did not activate the alarm when pulled.

On May 1, 2015, it was confirmed by an identified PSW that the call bell continued to be wrapped around the grab bar and was not activating the alarm when pulled.

Interview with the DOC confirmed that call bells should not be wrapped around grab bars to ensure that they can be used by residents and staff at all times. [s. 17. (1) (a)]

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 resident-staff communication and response system can be used by residents and staff at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of the home's "Licensee Confirmation Checklist Infection Prevention and Control" indicated that residents are not offered immunization against tetanus and diptheria.

Interview with the lead for the home's infection prevention and control (IPAC) program confirmed that residents are not routinely offered immunization against tetanus and diphtheria unless ordered by the resident's physician. The lead confirmed that the home does not track residents who require a booster shot according to immunization schedules posted on the Ministry website. Link to immunization schedule: http://www.health.gov.on.ca/en/pro/programs/immunization/docs/immunization_schedule.pdf [s. 229. (10) 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 residents are offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date, it was observed that a sign was posted on resident #011's door that included personal health information. This observation was confirmed by an identified registered staff member.

Interview with the DOC confirmed that this practice does not respect resident #011's right to have his/her personal health information kept confidential. It was confirmed that the expectation is for all residents to have his/her personal health information kept confidential. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

On May 4, 2015, at 2:35p.m., the beverage/snack cart for the third floor (Fisher unit) was observed parked in the servery and ready for service. The cart contained a tray of cookies covered in saran wrap, a pot of tea/coffee, jugs of juice/milk and cups/mugs. One hour later at approximately 3:35p.m. the cart remained in the servery untouched.

Review of the meal service schedule confirmed that the afternoon beverage service is to take place at 2:30p.m. Interview with an identified PSW confirmed that it is the responsibility of the day PSWs to serve the 2:30p.m. beverage.

Interview with a dietary aide at 3:35p.m. confirmed that the snack cart remained untouched and that the 2:30p.m. afternoon beverages had not been served. Interview with an identified registered staff member confirmed that the day PSW shift had ended and the staff members had left without serving the afternoon beverages.

An interview with the DOC confirmed that the expectation is for residents to be provided an afternoon beverage. [s. 71. (3) (b)]

2. The licensee has failed to ensure that residents are offered a minimum of a snack in the afternoon and evening.

On May 4, 2015, at 2:35p.m., the beverage/snack cart for the third floor (Fisher unit) was

observed parked in the servery and ready for service. The cart contained a tray of cookies covered in saran wrap, a pot of tea/coffee, jugs of juice/milk and cups/mugs. One hour later at approximately 3:35p.m. the cart remained in the servery untouched.

Review of the meal service schedule indicated that snack service is to take place at 2:30p.m. Interview with an identified PSW confirmed that it is the responsibility of the day PSWs to serve the 2:30p.m. snack.

Interview with a dietary aide at 3:35p.m. confirmed that the snack cart remained untouched and that the 2:30p.m. snack had not been served. Interview with an identified registered staff member confirmed that the day PSW shift had ended and the staff members had left without serving the afternoon snack.

An interview with the DOC confirmed that the expectation is for residents to be provided with an afternoon snack. [s. 71. (3) (c)]

3. The licensee has failed to ensure that planned menu items are offered and available at each meal.

On April 22, 2015, at 1:15p.m., it was observed that residents were not served apple maple bread pudding for dessert as per the posted daily and weekly menus.

An identified dietary aide confirmed that a Boston cream cake was being offered instead of the apple maple bread pudding.

An interview with the Food Services Manager (FSM) confirmed that the expectation is for planned menu items to be offered and available at each meal. [s. 71. (4)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home are posted in the home.

On April 22, 2015, the inspector observed the following critical incident report was not posted: 2014_219211_0010. On April 22, 2015, the inspector observed the following complaint report was not posted: 2013_102116_0043.

Interview with the DOC confirmed that the above mentioned inspection reports were not posted as required. [s. 79. (3) (k)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Review of Critical Incident Report #C603-000002-15 indicated that the home reported they declared an outbreak of influenza on January 29, 2015. This report was submitted to the Director under the LTCHA on February 19, 2015.

Interview with the home's DOC confirmed that the home did not immediately report the outbreak in as much detail as was possible, to the Director. [s. 107. (1) 5.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observations on the afternoon of May 1, 2015, revealed that items other than drugs or drug-related supplies were stored in the medication cart on the fourth floor (Moore unit). Inside the narcotic drawer of the medication cart two envelopes containing sums of money were stored together with 14 blister packs containing narcotics. Both envelopes were labeled with a date and a resident's name.

Interview with an identified registered staff member confirmed that only narcotics should be stored in the narcotic drawer, but because it is double locked, the drawer is sometimes used for the safekeeping of items other than drugs.

Interview with the home's DOC confirmed that envelopes containing money should not be stored in the medication cart. [s. 129. (1) (a)]

Issued on this 18th day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH KENNEDY (605), STELLA NG (507), SUSAN LUI (178)
Inspection No. / No de l'inspection :	2015_398605_0013
Log No. / Registre no:	T-001681-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 11, 2015
Licensee / Titulaire de permis :	THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA 2 OVERLEA BLVD, TORONTO, ON, M4H-1P4
LTC Home / Foyer de SLD :	ISABEL AND ARTHUR MEIGHEN MANOR 155 MILLWOOD ROAD, TORONTO, ON, M4S-1J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Coventry

To THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_357101_0057, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must ensure that locks on servery doors are in place and functioning at all times. A system must be developed to ensure the servery doors are monitored regularly. If the doors are not working, immediate action for correction must be taken.

Grounds / Motifs :

1. The licensee failed to comply with order CO#001, originally issued May 9, 2014, during the 2014 RQI #2014_321501_0003, with an order compliance date of June 30, 2014. The order directed the home to ensure residents did not have access to non-residential areas when unattended by staff (i.e. unit serveries, dish wash areas and service elevators).

This order was followed-up on January 26, 2015, and was still not in compliance. Therefore, the order was re-issued with inspection #2014_357101_0057 with an order compliance date of February 27, 2015. The re-issued order required the licensee to prepare, submit and implement a plan to ensure that all doors in resident home areas that lead to non-residential areas, including, but not limited to, serveries with hot holding areas, and a dish wash area with access to the service elevator, are kept closed and locked when unattended by staff to restrict resident access. The plan shall include: immediate actions to ensure the 2E servery is restricted to residents when unattended by staff as this door could not be locked at the time of inspection, immediate short-term and long-term actions taken to ensure access to all serveries in the home are restricted to residents when unattended by staff. The licensee submitted the plan to inspector #101.

On April 22, 2015, at the commencement of this inspection (RQI #2015_398605-0013), the licensee failed to comply with the order issued twice before. (605)

2. The licensee has failed to ensure that the home's environment is kept safe and secure for its residents.

Observations on April 22, 2015, at 11:05 a.m., revealed that the door from the dining room to the servery on the third floor (Lawrence unit) was unlocked and ajar. Located in the servery was a coffee maker, an oven and warming tables. The warming tables were on and hot under the stainless steel covers. A pocket door from the servery to the dish washing area was closed and locked. One resident was observed sitting at a table in the dining room. No staff were present in the area at the time. An identified registered staff member summoned to the area confirmed that the servery door should be locked when not supervised. (178)

3. Observations on Friday April 24, 2015, at 3:30 p.m., revealed that the door to the servery on the second floor (Coombs unit), a secure unit, was not locked. Located inside the servery was an oven, warming tables, and a hot water dispenser. The pocket door from the servery to the dishwashing area was closed, but not locked. Located inside the dish washing area was a commercial dishwasher and a service elevator with a key in the lock. No staff were present in the servery or dish washing area at the time. No residents were in the dining room or servery area at the time. An interview with an identified registered staff member confirmed that the door to the servery was not locked and stated that the door should have been locked because a resident could be harmed by the equipment within the servery. The identified registered staff member had to slam the servery door forcefully three times in order to engage the lock. The identified staff member confirmed that the unit is home to a number of cognitively impaired residents, some of whom wander. At 3:40 p.m., an identified dietary aide entered the servery having returned from a break. The identified staff member stated that the doors to the servery and the dish washing area were not locked because the locks were not functioning properly, the locks had been repaired unsuccessfully in the past, and that management and maintenance staff were aware that the locks are not functioning properly. (178)

4. On May 5, 2015, the second floor (Coombs unit) servery door was found open and unlocked. Staff were not present at this time. Further observation revealed

that there was a sharp knife in a drawer. Interview with an identified staff member confirmed that the servery door was left open and the lock was not functioning. (605)

5. On May 5, 2015, the third floor (Fisher unit) servery door was found open and unlocked. Staff were not present at this time. Interview with an identified staff member confirmed that there was a sharp knife stored in one of the servery drawers. Further inspection revealed that the servery door lock had fallen off the door and was placed on the counter. (605)

An interview with the Executive Director (ED) confirmed that the serveries and dish washing areas should be secured and locked and that the servery doors and locks which are presently in place are not sufficient. (605)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 18, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Kennedy

Service Area Office /
Bureau régional de services : Toronto Service Area Office