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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Apr 29, 2016	2016_252513_0005	007797-16	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

JUDITH HART (513), ARIEL JONES (566), SARAH KENNEDY (605), SOFIA DASILVA (567), 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): March 16, 17, 18, 21, 22, 24, 29, 30, 31, April 1, 4, and 5, 2016.

Four critical incident (CIR) and two complaint inspections were conducted concurrently with this RQI inspection and results are included in this report. CIR intakes include #025907-15, #030261-15, #008107-16 and #008107-16. Complaint intakes include: #018098-15 and #030273-15.

In addition, an inspection was conducted for complaint intake #002445-14 and these results will be available in a separate report #2016_417178_0005.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Director of Care (IDOC), Director of Care (DOC); Director of Employee Relations (DER), Facilities and Environmental Services Manager (FESM), Resident Assessment Instrument (RAI) Coordinator, receptionist, registered nurses (RN), registered practical nurses (RPN), former assistant Director of Care (ADOC), Physiotherapist (PT), personal support workers (PSW), Dietary Aides (DA), Housekeeper, Recreation Aide (RA); Residents' Council President, Family Council representatives, residents, family members and private caregivers.

During the course of the inspections, the inspectors toured the home, observed resident care, observed staff to resident interactions, observed meal service, reviewed resident health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
3 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #021 was protected from abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act,
- “verbal abuse” means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident;
- “emotional abuse” means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A review of the Critical Incident Report (CIR) revealed that on a specified date in 2015, staff member #109 verbally and emotionally abused resident #021. The staff member verbally abused resident #021 by calling him/her a vulgar name. The staff member abused the resident emotionally by saying he/she was disliked by staff and by frightening the resident.

A review of the home's investigation report of the incident revealed staff #109 committed verbal and emotional abuse toward resident #021.

An interview with resident #21 confirmed that staff member #109 called the resident a vulgar name and frightened the resident. The resident also stated that staff #109 told him/her he/she was not liked by staff #109 and other staff members.

An interview with the Director of Employee Relations confirmed that the home substantiated the resident's allegation that staff #109 had verbally and emotionally abused the resident and as a result staff #109's employment was terminated. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A review of the CIR, submitted by the home on a specified date in 2015, revealed that resident #007 sustained an injury for which the resident was sent to hospital. On a specified date, two identified PSWs transferred resident #007 from his/her bed to his/her wheelchair using a mechanical lift. During the transfer, the lift tilted to one side and the resident fell onto the floor. Resident #007 was sent to hospital for treatment for a specified injury.

PSW #111 and PSW#137 were transferring resident #007 at the time of the incident. Interviews with both PSWs confirmed the lift fell completely over and resident #007 fell to the floor sustaining an injury. The PSWs were not able to identify what caused the lift to tip.

An interview with the physiotherapist confirmed that the lift was acceptable to use with resident #007. An interview with the Facilities and Environmental Services Manager (FESM) revealed the lift was assessed after the fall and there were no identified concerns.

An interview with the Interim Director of Care (IDOC) revealed no one was able to identify what caused the lift to fall, causing injury to the resident. The IDOC confirmed that the expectation is for staff to use safe transferring and positioning techniques when assisting residents. Resident #007 was not transferred safely as he/she fell and sustained an injury. [s. 36.]

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 use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents’ Council and Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interviews with the president of the Residents’ Council and representatives of the Family Council revealed no one from the home asked these Councils for input in developing and carrying out the satisfaction survey.

Interviews with the assistant of both Councils confirmed both Councils did not have input in developing and carrying out the satisfaction survey. The assistant revealed the survey questions were developed externally through a group of homes identified by a specific title and there was no opportunity for the Residents’ and Family Councils to provide any input or feedback on the survey questions.

An interview with the ED confirmed the home had not sought the input of Residents’ and Family Councils in developing and carrying out the satisfaction survey. (567) [s. 85. (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 the licensee seeks the advice of the Residents’ Council and Family Council in developing and carrying out the satisfaction survey, and in acting on its results, 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 equipment was kept clean and sanitary.

An observation on a specified date in 2016, revealed the knob on the front of a raised toilet seat in resident #012's bathroom was soiled with brown debris. An observation on a subsequent date revealed the knob remained soiled.

An interview with staff #116 confirmed there was brown debris on the raised toilet seat in resident #012's bathroom and the toilet was not kept clean.

An interview with the Facilities and Environmental Services Manager (FESM) revealed the toilet was not kept clean. The expectation is for equipment to be kept clean and sanitary. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director under the LTCHA.

A review of the CIR revealed that on a specified date in 2014, resident #022 reported to a student, who was performing a placement at the home, that he/she had been abused by two staff members. This allegation was reported to the DOC on a specified date. The CIR detailing this allegation was not submitted to the Director under the LTCHA until two weeks later, on a specified date in 2014.

An interview with the home's IDOC confirmed that the CIR was submitted late and that the allegation should have been immediately reported to the Director under the LTCHA. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident’s care is held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident’s substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to resident #011 and his or her substitute decision-maker (SDM), if any, at least annually.

An interview with the SDM for resident #011 revealed that an annual care conference had not been held in 2014 and 2015.

A review of resident #011’s progress notes and medical chart did not reveal documentation related to annual care conferences in either 2014 or 2015. An interview with the social worker (SW) revealed that a care conference was offered to the SDM of resident #011 in 2015 but that he/she could not attend. The SW revealed the home had offered to reschedule the annual care conference with the SDM, but a care conference had not been scheduled.

An interview with the SW and the IDOC confirmed that annual care conferences were not held for resident #11 in 2014 and 2015. [s. 27. (1)]

WN #7: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

An observation on a specified date in 2016, identified a tube of medicated ointment in resident #013's bath room.

An interview with resident #013 confirmed that she/he self-administers the medicated ointment to areas on the face.

A review of the resident's physician prescriptions did not reveal a self-medication prescription for medicated ointment.

An interview with registered staff #129 confirmed that there was no physician prescription for resident #013's self-administration of medicated ointment. An interview with the IDOC confirmed that a physician prescription was required in consultation with resident #013 in order for the resident to self-medicate with the ointment. [s. 131. (5)]

Issued on this 3rd day of May, 2016

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

Original report signed by the inspector.