Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 8, 2021	2020_642698_0020	010587-20	Complaint

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

ORALDEEN BROWN (698)

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): December 8, 10, 11, 14, 15, 2020. Off-site: December 21 and 22, 2020.

The following intake was completed during the course of this inspection:
Log #010587-20 related to multiple care areas.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and family.

During the course of the inspection, the inspector(s) conducted observations of resident, staff and resident interactions and the provision of care; conducted review of resident health records, the home's internal investigation notes, complaint records, email complaints, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. a. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided when a device was not applied while up in their mobility device.

During an observation in the resident's room, inspector noted that the device was not applied.

During an interview with a PSW, they indicated that the resident's device should be applied while in bed and also while up in their mobility device. During an interview with ED, they indicated that the resident's care plan was not followed when the PSW did not apply the device.

Sources: review of electronic records and staff interviews.

b. The licensee failed to ensure that the care set out in the plan of care for a resident was provided when the bowel protocol was not initiated.

A complaint was made to Inspector 698 during an inspection at the Long-Term Care Home (LTCH) regarding a resident not being given bowel protocol for absence of bowel movement (BM) for a period of time.

Record reviews of the electronic documents and chart indicated that the resident had no bowel movements for a period of time. The resident's care plan indicated that they had a bowel protocol in place. The electronic documents indicated that the family was notified after several days and a new medication was ordered and administered.

Interview with an RPN indicated that the resident did not receive bowel protocol interventions as specified in the plan of care.

Sources: electronic records, resident's chart, activities of daily living policy and staff interviews. [s. 6. (7)]

2. The licensee has failed to ensure that different approaches were considered when a resident's care plan was revised and had not been effective.

Record review of a resident's care plan indicated they were at high risk for falls but was not placed on the Falls Prevention and Management Program.

Interview with Physio Therapist Assistant (PTA) indicated that the resident was not in the Falls Prevention and Management Program and should have been placed on the program once they were high risk.

Sources: electronic records, resident's chart, fall prevention prevention program policy, staff and family interviews. [s. 6. (11) (b)]

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 a. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan;
b. When a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care;
c. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy was complied with when the Substitute Decision Maker (SDM) for a resident was not notified after a fall.

Review of the resident's progress notes indicated that they sustained a fall and the registered staff endorsed to the oncoming shift to notify the resident's SDM. An incident report was completed but the SDM was not notified of the incident involving the resident the following day or thereafter. Review of the Fall Prevention Program policy #06.24 revision date October 31, 2018, indicated that family should be notified when a resident has a fall.

Interview with the ED indicated that the policy was not followed when the registered staff did not notify the SDM of resident's incident.

Sources: electronic records, fall prevention program policy review and staff interview. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 19th day of January, 2021

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

Original report signed by the inspector.