Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

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

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 20, 21, 22, 23, 24, 28, 29, 30, 31, Sep 5, 6, 7, 10, 11, 2012	2012_083178_0028	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

SUSAN LUI (178), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Executive Director, Acting Director of Care (DOC), Assistant Director of Care (ADOC), Registered Staff, Personal Support Workers (PSWs), attending Physician, Certified Enterostomal Therapist, residents, family member of a resident, friend of a resident.

During the course of the inspection, the inspector(s) observed resident care, reviewed resident records, reviewed home's policies and procedures.

The following LOGs were inspected as part of this inspection:
T-2884-11, T-00135-12, T-155-12, T-227-12, T-253-12, T-268-12, T-199-12, T-238-12, T-258-12, T-279-12, T-298-12, T-299-12, T-300-12, T-358-12, T-467-12, T-449-12, T-543-12, T-552-12, T-556-12, T-1083-12, T-1212-12, T-1368-12, T-1431-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Dignity, Choice and Privacy

Dining Observation

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for Resident number 1 was provided as specified in the plan.

On the afternoon of August 21, 2012, the resident was offered and accepted items from the snack cart which, according to the resident's plan of care, were not to be served to the resident.

2. Staff interviews and record review indicate that Resident number 1 was using a device to prevent skin breakdown. Record review and interviews with family and the home's contracted staff indicate that on two occasions the resident's device to prevent skin breakdown was found to be under-inflated and therefore not providing the resident with the protection against skin breakdown which the resident required.

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 care for Resident number 1 is provided as specified in the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one Registered Nurse (RN) is on duty and present in the home at all times.
The home's acting Director of Care confirmed that an RN who is both an employee of the licensee and a member of the regular nursing staff of the home was not on duty and present in the home on twelve different occasions since January 2012. An Agency RN was on duty and present in the home on these occasions.

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 at least one Registered Nurse (RN) is on duty and present in the home at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
Record review and staff interviews confirmed that on the evening of March 27, 2012 an identified registered staff member failed to administer an identified medication to Resident number 1 in accordance with the directions for use as specified as by the prescribing physician.

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 Resident number 1's identified medication is administered in accordance with the directions for use as specified by the prescribing physician, to be implemented voluntarily.

issued on this 12th day of September, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Susan Lin (178)