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

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

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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
Jan 26, 2015	2014_357101_0057	T-734-14;T-735-14	Follow up

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

AMANDA WILLIAMS (101)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 15, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care, Assistant Director of Care, Environmental Services Manager and the Administrator.

During the inspection the inspector observed resident dining rooms, both residential and non-residential areas.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 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. 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 previous order CO#001 issued May 9, 2014 during the 2014 RQI inspection #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 area and service elevator). [s. 5.]

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

On December 15, 2014 at ~11:30am, the 2E servery door was observed to be broken, and as a result, unable to be locked and restrict resident access to the servery and subsequently a set of pocket doors that lead to the dish wash area and service elevator. It was noted at the time of inspection that the pocket door leading to the dish wash area and service area was left unlocked, however, a dietary staff was present in the dish wash area at the time of inspection. [s. 5.]

3. On December 15, 2014 at ~12pm, a hot plate was observed to be left on and unattended with a kettle on top in the 4E servery presenting a potential scalding/burn hazard to residents. The door leading into the servery was observed to be left open and unlocked. Staff were not present in the area at the time of observation. Interview and observation with the Environmental Services Manager and Assistant Director of Care revealed that all servery doors are to be kept closed and locked when unattended by staff. [s. 5.]

4. On December 15, 2014 at ~12pm, the 4W servery and dish wash area door that provides access to the service elevator was observed to be open, unlocked and unattended by staff. It was also observed by walking through the dish wash area to the 4E side that the servery door and dish wash door were also left unlocked, open and unattended by staff at the time of inspection. [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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to comply with previous order CO#002 issued May 9, 2014 during the 2014 RQI inspection #2014_321501_0003 with an order compliance date of June 30, 2014. The order directed the home to ensure all resident beds with bed rails have all zones of entrapment eliminated. [s. 15. (1) (a)]

2. The licensee has failed to ensure that resident bed systems have been evaluated in accordance with evidence-based practices.

Interviews with the Environmental Services Manager, Director of Care and Assistant Director of Care revealed that the home has replaced all bed rails on resident beds with 1/4 rails and replaced 40 resident mattresses with custom mattresses to eliminate previously identified zones of entrapment on resident bed systems. However, the home did not re-evaluate resident beds using the approved instrument once the modifications were completed to the resident bed system to verify that all zones of entrapment have been eliminated as per Health Canada's document entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". [s. 15. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of January, 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) :	AMANDA WILLIAMS (101)
Inspection No. / No de l'inspection :	2014_357101_0057
Log No. / Registre no:	T-734-14;T-735-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 26, 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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_321501_0003, 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 shall 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 taken to ensure the 2E servery is restricted to residents when unattended by staff as this door could no 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 plan shall be submitted to Amanda.Williams@ontario.ca no later than Friday February 9, 2015.

Grounds / Motifs :

1. The licensee failed to comply with previous order CO#001 issued May 9, 2014 during the 2014 RQI inspection #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 area and service elevator). (101)

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

On December 15, 2014 at ~11:30am, the 2E servery door was observed to be broken, and as a result, unable to be locked and restrict resident access to the servery and subsequently a set of pocket doors that lead to the dish wash area and service elevator. It was noted at the time of inspection that the pocket door leading to the dish wash area and service area was left unlocked, however, a dietary staff was present in the dish wash area at the time of inspection. (101)

3. On December 15, 2014 at ~12pm, a hot plate was observed to be left on and unattended with a kettle on top in the 4E servery presenting a potential scalding/burn hazard to residents. The door leading into the servery was observed to be left open and unlocked. Staff were not present in the area at the time of observation. Interview and observation with the Environmental Services Manager and Assistant Director of Care revealed that all servery doors are to be kept closed and locked when unattended by staff. (101)

4. On December 15, 2014 at ~12pm, the 4W servery and dish wash area door that provides access to the service elevator was observed to be open, unlocked and unattended by staff. It was also observed by walking through the dish wash area to the 4E side that the servery door and dish wash door were also left unlocked, open and unattended by staff at the time of inspection.

(101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_321501_0003, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure where bed rails are used, the residents' bed system is evaluated in accordance with Health Canada's document entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" to ensure all zones of entrapment or other safety issues are eliminated.

Grounds / Motifs :

1. The licensee failed to comply with previous order CO#002 issued May 9, 2014 during the 2014 RQI inspection #2014_321501_0003 with an order compliance date of June 30, 2014. The order directed the home to ensure all resident beds with bed rails have all zones of entrapment eliminated. (101)

2. The licensee has failed to ensure that resident bed systems have been evaluated in accordance with evidence-based practices.

Interviews with the Environmental Services Manager, Director of Care and Assistant Director of Care revealed that the home has replaced all bed rails on resident beds with 1/4 rails and replaced 40 resident mattresses with custom mattresses to eliminate previously identified zones of entrapment on resident bed systems. However, the home did not re-evaluate resident beds using the approved instrument once the modifications were completed to the resident bed system to verify that all zones of entrapment have been eliminated as per Health Canada's document entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". (101)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 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 26th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA WILLIAMS

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