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

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

Division des foyers de soins de longue durée
Inspection de soins 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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2017	2017_685648_0013	003636-17	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

JOVAIRIA AWAN (648), SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 4, 5, 6, 10, 11, 12, and 13, 2017.

The following intakes were inspected concurrently with the Resident Quality Inspection:
Critical Incident Systems (CIS):
#C630-000001-15 - related to an unwitnessed fall.
#C603-000001-17- related to an injury resulting in hospitalization.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Facilities and Environmental Services Manager (FESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aides (HKA), and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #007 was identified to have returned from hospital on an identified date with an identified diagnoses, and a modified fluid consistency intervention. Resident #007's eMAR and electronic written plan of care reveiwed in PCC identified he/she was at high nutrition risk, and included his/her nutrition care interventions such as the provision of the modified fluid consistency and oral nutrition supplementation.

Observations conducted during the course of this inspection prompted further review of the oral nutrition supplementation and fluid consistency for resident #007 as follows:

PSW #104 provided resident #007 with an oral nutrition supplement in the modified fluid consistency as prescribed and assisted resident in drinking the oral nutrition supplement. During this observation period PSW #104 was observed to take regular/thin consistency water and pour into the glass of oral nutrition supplement in which there was leftover fluid, consequently diluting and altering the fluid consistency, and proceeded to feed the fluid to the resident.

Review of resident #007's written plan of care on with PSW #104 identified resident #007 was to be offered the prescribed modified fluid consistency as noted. PSW #104 confirmed that the fluids provided to resident #007as noted in the observation above were diluted to change the fluid consistency, and that he/she had not provided care specified in the plan.

Interview with RN #105 identified resident #007's nutrition interventions including modified fluid consistency to manage swallowing difficulty as noted in the written plan of care. Observations as noted above were reviewed with RN #105 and he/she confirmed resident #007 was not provided the correct fluid consistency as prescribed and that provision of the oral nutrition supplement as reported by PSW #104 was inconsistent with specified care planned for resident #007.

Observation's as noted above of PSW #104, and staff reports as noted above were reviewed with the DOC. The DOC identified staff were expected to provide assessed fluid consistencies to residents to maintain safe swallowing, and identified provision of diluted fluids to resident #007 would pose a safety risk. The DOC acknowledged resident #007 was not provided care as specified in his/her plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On an identified date, the licensee submitted a critical incident system to the Director for an incident that caused an injury to resident #001 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CIS identified PSW staff informed a registered staff member at an identified time of resident #001's fall on the facility premises. The resident was observed to have fallen. As per the PSW, the resident's personal mobility device was overturned when he/she found the resident who appeared to be alert and vocalized discomfort. A good samaritan who lived across from the home heard resident #001, and called 911. Resident #001 was transferred to the hospital and sustained an injury.

Review of the homes internal investigation notes and interviews held with the DOC and FESM indicated the home's theory is that resident #001 left the home on the identified date, through the fire door located within the administration wing.

For the period of of the inspection, inspector #116 observed that the main access doors to the administration area was equipped with a locking mechanism however, the inspector was able to gain access to the administration area as it was unlocked. The administration area leads to a fire exit door that leads to an unsupervised area outside of the home. The fire exit door located in the administration area was observed to be equipped with a keypad however, the door was unlocked providing inspector #116 to gain access to the outside.

Further interviews held with the DOC and the facilities manager confirmed that the main door and the fire exit door located in the administration wing leading to a non-residential area was not equipped with a lock to restrict unsupervised access to those areas by residents. [s. 9. (1) 2.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Resident #001's single occupant room was identified during the inspection with a room odour during observations.

Observations were conducted of resident #001's room area throughout the inspection period on multiple identified instances. An offensive lingering odour was noted in the resident's room during the entire set of observations conducted during the inspection. .

Review of the homes maintenance logs including the period up to and and including the inspection period, did not identify that staff had communicated the persistent offensive odour in resident #001's room to the FESM for further mitigation.

Review of the Housekeeping Service Outline Policy (4-1; Environmental Services Manual, January 2015) did not identify procedures developed for addressing incidents of lingering offensive odours in home.

Interview with HKA #106 identified the homes process included daily standard cleaning of resident rooms and bathrooms, and a deep cleaning on a bi-weekly basis. The standard cleaning routine included sweeping and mopping of resident bathroom floors, vacuum of the resident room carpets, removal of debris and waste from the bathroom and room, and additional cleaning of fixtures. In addition to the standard cleaning routine, the deep cleaning of a resident room included shampooing of the carpet, a thorough cleaning of the resident bathroom and room including mirror, walls, toilet, fixtures, furniture, and cupboards. Furnishings and fixtures in the resident room were to be cleaned in a similar manner. HKA #106 identified that the Bio-Enzymatic Eliminator chemical was utilized as a standard intervention for rooms with lingering offensive odours on a weekly basis. HKA #106 confirmed resident #001 was known to him/her for the

described the odour to smell like urine. The HKA demonstrated that resident #001's room was provided a deep cleaning on and identified date. HKA #106 acknowledge the lingering odour remained present in the resident room at the time of the inspection. Upon further inquiry, HKA #106 was unable to demonstrate whether the home had procedures in place to manage persistent lingering offensive odours.

Interview with PSW #108 identified resident #001's room was known to staff to have a persistent offensive odour. PSW #108 indicated he/she did not document housekeeping concerns related to offensive odours in the maintenance logs, and was to report concerns to registered staff. However, PSW #108 was unable to clarify or demonstrate if he/she had notified registered staff of resident #001's room odour.

Interview with RPN #109 identified housekeeping concerns would be communicated to the FESM through the maintenance logs available to staff at the nursing stations and the main floor reception. RPN #109 indicated PSW staff were to report concerns to the registered staff or housekeeping staff, and were also able to document in the maintenance request books. Observations conducted with RPN #109 confirmed a persistent offensive odour in resident #001's room, described as a stale urine odour. RPN #109 was unable to demonstrate if the concern had been communicated to the FESM in the maintenance request log.

Interview with the FESM reiterated that the home provided standard daily cleanings to all resident rooms and bathrooms, and a deep cleaning on a bi-weekly basis. Observations conducted with the FESM confirmed resident #001's room to have an persistent offensive odour present. The FESM identified that staff were to inform him/her of concerns related to housekeeping for resident rooms including persistent offensive odours by documenting in the maintenance log available at each nursing station in the home and at the reception on the main floor.

Interview with the DOC confirmed he/she had made observations and was aware that resident #001'S room had a lingering offensive odour, The DOC acknowledged the home had was unable demonstrate that procedures had been development and implemented in order to address the lingering offensive odour in resident #001's room. [s. 87. (2) (d)]

Issued on this 7th day of December, 2017

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

Original report signed by the inspector.