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
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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
Jan 25, 2018	2018_486653_0001	020231-17, 020741-17	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

ROMELA VILLASPIR (653)

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): January 3, 4, 5, 9, and 10, 2018.

The following intake was inspected concurrently during this inspection: Log #020231-17.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed staff schedule, clinical health records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the resident, Substitute Decision-Maker (SDM), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), RAI-MDS Back Up Nurse, Nurse Designate (ND), Director of Care (DOC), and the Executive Director.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
1 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 has failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONLine received a complaint on an identified date, related to the care of resident #001.

The concerns from the complainant were as follows:

-On an identified date, the resident was diagnosed with an unexplained injury.
-The resident stated to the Substitute Decision-Maker (SDM) that they had been dropped on the floor while being transferred from the bed to their wheelchair.

Review of resident #001's health records indicated they were admitted to the home on an identified date, with an identified medical diagnosis, and medical history.

Review of resident #001's progress notes within an identified time period, revealed the following:

-On an identified date and time, the resident complained of pain on an identified area of the body. An identified as needed medication was given. At an identified time, the Physiotherapist (PT) assessed the resident as they had complained of constant localized aching pain in their identified body part which started in the morning. No injury or incident as per the resident and Personal Support Worker (PSW). Later in the afternoon the attending physician had seen the resident and documented that resident #001 had pain, and signs of injury to an identified body part. The attending physician ordered further identified assessments for the two identified body parts.

-On an identified date and time, Registered Nurse (RN) #104 documented, that resident #001 complained of pain on an identified body part, especially upon movement during care. An identified as needed medication had been given to the resident at an identified time, and an order for an assessment for the identified body part was obtained from the attending physician. The resident denied any pain when reassessed by the RN. Registered Practical Nurse (RPN) #102 documented at an identified time, that they noted signs of injury on the identified body part, and the resident complained of pain to an identified body part. An as needed medication had been given to the resident with good effect. Resident's SDM aware of new orders.

-During an identified period of time, the resident continued to complain of pain on the identified body part. On an identified date and time, the resident was sent to hospital for further assessment and returned the same day at a later time with an identified medical diagnosis. A review of the hospital's emergency record revealed there was no significant

injury.

-On an identified date, a further assessment was done at the home on the resident's two identified body parts. Later on in the evening, results had been received and did not indicate any injury. The on-call physician ordered a further identified assessment to the identified body part for a more detailed evaluation.

-On an identified date and time, the attending physician had seen the resident noting changes to an identified body part. On the same day, at a later time, RPN #102 received a verbal report from the diagnostic company confirming injury on the resident's identified body part. On-call physician was notified, and the resident was sent to the hospital.

Review of the resident's hospital note on an identified date, revealed that the resident sustained another injury to a different body part during the identified procedure.

Review of the resident's identified discharge summary on an identified date indicated that the resident was at high risk for recurrent injury.

Review of resident #001's identified assessment on an identified date, revealed they were totally dependent on staff, and received two person physical assist for bed mobility, dressing, and personal hygiene.

Interviews with day, evening, and night PSWs #108, #109, #110, #114, and #115, stated that the resident was total care and required two staff assistance prior to sustaining the injury, due to physical limitations. Interviews with day, evening, and night RPNs #102, #116, and RNs #101, 104, #111, and the RAI-MDS Back Up Nurse indicated that the resident had an identified medical diagnosis, and required two staff assistance for care even prior to sustaining the injury.

Interview with PSW #107 stated that prior to the resident sustaining the injury, the PSW provided morning care to the resident and turning them in bed unassisted at times. The PSW provided the resident's care that morning when the resident initially complained of pain on the identified body part. PSW #107 provided care to the resident as usual, and while giving care, right after the PSW turned the resident on their side, the resident complained of pain on the identified body part. The PSW provided the care by themself that morning, and continued the care because the resident was not in great pain. The resident remained in bed, and the PSW notified the RN and the PT after the care was finished. PSW #107 acknowledged that the resident required two staff for care and in

hindsight, the PSW would have asked for another PSW to assist with resident #001's care.

Interview with the Director of Care (DOC) stated that a resident's plan of care indicated how the care will be provided to the resident. The DOC also indicated that resident #001 had always been very fragile due to their medical diagnosis, and so required two staff for care. The DOC acknowledged the above mentioned information, and confirmed that in this case, care had not been provided to the resident as specified in the plan of care. They further acknowledged that providing the care to the resident with only one staff instead of two staff as required, had resulted to a risk of harm to the resident.

The severity of the non-compliance was actual risk.

The scope of the non-compliance was isolated to resident #001.

A review of the home's compliance history within the last three years revealed Voluntary Plan of Corrections (VPCs) were previously issued for noncompliances related to the Long-Term Care Homes Act, 2007, s. 6. within the following inspection reports:
-#2016_417178_0005 dated May 3, 2016,
-#2015_398605_0013 dated June 11, 2015. [s. 6. (7)]

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 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 a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 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.

The MOHLTC ACTIONLine received a complaint on an identified date, related to the care of resident #001.

The concerns from the complainant were as follows:

-On an identified date, the resident was diagnosed with an unexplained injury.
-The resident stated to the SDM that they had been dropped on the floor while being transferred from the bed to their wheelchair.

On an identified date and time, the home submitted a Critical Incident Report (CIS), related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status. The CIS indicated that on an identified date and time, RPN #102 received a verbal report from the diagnostic company confirming injury on the resident's identified body part. RPN #102 notified the on-call physician and they ordered to send the resident to the hospital.

Review of resident #001's diagnostic results for the identified body part on an identified date, revealed an identified injury.

Review of progress note on identified date and time, indicated that the resident's SDM was informed that resident #001 had been sent to the hospital due to an injury. The SDM was very upset and that someone must have been abusing the resident. The SDM requested a full investigation, and RPN #102 informed the Nurse Designate (ND) and the DOC.

Review of the home's policy titled “Resident Non-Abuse: Zero Tolerance of Abuse and Neglect of Residents” policy #1.12, revised February 2016, indicated that one of the indicators of abuse was unexplained injuries.

Interview with RPN #102 stated that the staff had not been aware of any incident that may have caused the injury. The RPN confirmed the above mentioned documentation and further acknowledged that the resident's SDM's statement was an allegation of abuse, and they reported it to the ND. Interview with RN #111 who was the ND that evening, confirmed the above mentioned documentation, and acknowledged it as an allegation of abuse.

Interview with the DOC stated they had been informed by RPN #102 regarding the conversation that transpired with the SDM, that same evening. On the following day, the DOC had spoken to the SDM and the SDM was upset and accusing the home of abuse. The DOC confirmed that in the event that a family member approaches the staff and alleges that abuse had happened to a resident, the MOHLTC would have to be called immediately. [s. 24. (1) 2.]

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 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: 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, to be implemented voluntarily.

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2018_486653_0001
Log No. / No de registre :	020231-17, 020741-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 25, 2018
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 :	Julie Wong

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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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The Licensee must be compliant with LTCHA, 2007, c. 8, s. 6 (7). Specifically, the Licensee shall ensure the following is in place for resident #001 and any other resident with similar physical needs:

1. Review the resident's current plan of care with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), and Registered Nurses (RNs), who are responsible for the resident's care. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.
2. Ensure all direct care staff that provide care to the resident, follow the plan of care regarding the number of staff required to provide assistance for bed mobility, transfers, continence care, and personal hygiene.
3. Review with all direct care staff the nature of this incident and the importance of providing care to the resident as specified in the plan. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.

The above mentioned documentation shall be available to the inspector upon request. This order shall be complied no later than April 25, 2018.

Grounds / Motifs :

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

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-During an identified period of time, the resident continued to complain of pain on the identified body part. On an identified date and time, the resident was sent to hospital for further assessment and returned the same day at a later time with an identified medical diagnosis. A review of the hospital's emergency record revealed there was no significant injury.

-On an identified date, a further assessment was done at the home on the

resident's two identified body parts. Later on in the evening, results had been received and did not indicate any injury. The on-call physician ordered a further identified assessment to the identified body part for a more detailed evaluation.

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and in hindsight, the PSW would have asked for another PSW to assist with resident #001's care.

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The severity of the non-compliance was actual risk.

The scope of the non-compliance was isolated to resident #001.

A review of the home's compliance history within the last three years revealed Voluntary Plan of Corrections (VPCs) were previously issued for noncompliances related to the Long-Term Care Homes Act, 2007, s. 6. within the following inspection reports:
-#2016_417178_0005 dated May 3, 2016,
-#2015_398605_0013 dated June 11, 2015. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 25, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 25th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

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