



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 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

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Dec 1, 5, 6, 12, 13, 19, 22, 23, 2011; Jan 3, 4, 16, 2012; 2011_102116_0001; 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

SARAN DANIEL-DODD (116)

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 The Administrator, Director of Care, Food service manager, Dietitian, a resident, Power of Attorney (POA) of resident, Recreational staff, Registered staff and personal support workers.

During the course of the inspection, the inspector(s) reviewed the health record of a resident, home's admission package, the following policies were reviewed: managing complaints and zero tolerance of abuse.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Snack Observation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for an identified resident that sets out clear directions to staff and others who provide direct care to the resident with respect to ensuring:
 1)two persons provide care to the resident at all times 2) dietary restrictions.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training
Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

- 1. The Residents' Bill of Rights.**
- 2. The long-term care home's mission statement.**
- 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.**
- 4. The duty under section 24 to make mandatory reports.**
- 5. The protections afforded by section 26.**
- 6. The long-term care home's policy to minimize the restraining of residents.**
- 7. Fire prevention and safety.**
- 8. Emergency and evacuation procedures.**
- 9. Infection prevention and control.**
- 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.**
- 11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training on the duty under section 24 to make mandatory reports.

Not all staff within the home have received training in the area of mandatory reporting under section 24 of the Act.

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 all staff at the home receive training on the duty under section 24 to make mandatory reports, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident's substitute decision-maker(SDM) was notified of the results of an alleged abuse immediately upon the completion.

WN #4: 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 were administered to an identified resident in accordance with the directions specified by the prescriber.

Issued on this 16th day of January, 2012

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



