Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2014	2014_219211_0010	T-584-13-T-220-14	Critical Incident System

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 27, 28, 31, April 1, 2014.

During the course of the inspection, the inspector(s) spoke with the director of care, physiotherapist, designated day nurse, registered nursing staff, personal support workers (PSW's) and residents.

During the course of the inspection, the inspector(s) observed provision of care, reviewed resident health records, and reviewed the licensee's policies.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure to inform the Director no later than one business day after resident #1 and #2's fall incidents that causes injuries and significant changes in their health condition for which residents were taken to a hospital.

Record review indicated that resident #1 sustained an injury after a fall on an identified date. The licensee was informed of the injury on the same day. Interview with an identified staff confirmed that the licensee did not informed the Director no later than one business day after resident #1 sustained an injury and a significant change in his/her health condition and for which the resident was taken to the hospital.

Record review indicated that resident #2 had a fall on an identified date. Record review indicated that the resident was transferred to the hospital on another identified date. The licensee was informed the next day that resident #2 sustained an injury. Interview with an identified staff and record review confirmed that the licensee did not informed the Director no later than one business day after the resident sustained an injury and a significant change in his/her health condition and for which the resident was taken to the hospital. The licensee did send a report in writing to the Director ten days later.

2. The licensee failed to ensure that a report was send in writing to the Director of any incident within ten days of becoming aware of the incident.
Resident #1 sustained an injury after a fall on an identified date. Interview with an identified staff and clinical record review confirmed that a report in writing to the Director was not sent within ten days of becoming aware of the incident.

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 the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident and within ten days of becoming aware of the incident, or sooner if required by the Director and makes a report in writing to the Director as required, to be implemented voluntarily.

Issued on this 9th day of April, 2014

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

Joelle Taillefer RN