



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

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**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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 9, 2014	2014_235507_0006	T-582-13/T-194-14	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

STELLA NG (507)

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): March 14, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 31 and April 1, 2014.

This inspection occurred concurrently with the resident quality inspection (RQI) report #2014_321501_0003.

PLEASE NOTE:

The following areas of non-compliance related to resident #001 were found and issued in the

RQI report #2014_321501_0003:

- 1. O.Reg. 79/10, s.30(2) related to documentation.**
- 2. O.Reg. 79/10, s.52(2) related to pain assessment.**

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), designated evening nurse, wound care nurse, registered nursing staff, personal support workers (PSWs), occupational therapist (OT), resident and substitute decision maker (SDM).

During the course of the inspection, the inspector(s) conducted observations and reviewed resident and home records.

The following Inspection Protocols were used during this inspection:

Medication

Pain

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

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
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services

Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,

- (a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
- (b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :



1. The licensee failed to ensure that the occupational therapy service for resident #001 is arranged or provided as required under section 9 of the Act.

Record review revealed and staff interviewed confirmed that resident #001's SDM requested an assessment for an assistive device for resident #001. Resident #001 was assessed by an OT and was provided a new assistive device for trial by the vendor. Adjustments to the assistive device were made for the following four months. On an identified date, the OT completed the assessment and the SDM was contacted by the vendor to sign the consent form in order to proceed with Assistive Device Program (ADP) application.

Record review revealed and interview with SDM confirmed that the SDM made requests for an OT assessment for resident #001's new assistive device on two identified dates because of resident #001's pain and the requests were made seven weeks after the OT completed the assessment. An identified staff recommended an OT assessment of resident's position on using the assistive device due to his/her pain on an identified date, and the home did not arrange the OT assessment for resident #001.

Record review revealed and staff interviews confirmed that the assistive device was picked up by the vendor two months later because resident #001's SDM stated that the assistive device was not comfortable for the resident. Interviews with POA and the DOC confirmed that a week after the assistive device was picked up, resident #001's SDM made another request for an OT assessment for resident #001, and was informed by the home that OT assessment cannot be provided at the time. The DOC confirmed that an OT assessment had not been completed and there were no plans for a referral nine weeks after the request was made. [s. 59. (b)]



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Issued on this 20th day of May, 2014

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

