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

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
May 9, 2014	2014_321501_0004	T-182-13	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

SUSAN SEMEREDY (501)

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 #003 were found and issued in the RQI report #2014_321501_0003:
1. LTCHA, 2007, s.6(4)(a) related to staff collaboration.
2. O.Reg. 79/10, s.8(1)(b) related to policies.
3. 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), assistant director of care (ADOC), registered nursing staff, personal support workers (PSWs), food services supervisor (FSS), social worker, and power of attorney (POA).

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:
Continence Care and Bowel Management
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Resident Charges

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

Record review revealed that resident #003 has a Power of Attorney (POA) for Personal Care who makes all treatment decisions on behalf of the resident.

Record review revealed and the DOC confirmed that for resident #003, the home did not receive consent for the following:
1. Review of the progress notes indicated that the resident was noted to be coughing with no fever by nursing on an identified date. The physician on call was paged and an order for cough medicine was received.
2. Review of the progress notes revealed that the resident started having loose bowel movements. The physician ordered an x-ray of the abdomen. The physician noted from the x-ray that there was some constipation and ordered a laxative.
Review of the paper chart and electronic progress notes indicates that the POA was not contacted regarding these changes in condition and treatments.

Progress notes revealed that the POA for resident #003 was upset that he/she had not been informed of the above treatments. Record review revealed that he/she had given a note to the home dated April 15, 2013, clarifying her wishes that prior to any medical test being undertaken or new medication being started, he/she will be contacted for consent. [s. 3. (1) 11. ii.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaint received concerning the care of a resident is forwarded to the Director.

Record review revealed that the POA provided the home with written complaints dated April 15, 16, 17, 22 and May 30, 2013, regarding the care of resident #003. Record review revealed and interview with the ED confirmed that these written complaints were not forwarded to the Director. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made by the complainant.

Record review revealed that the POA of resident #003 provided the home with written complaints dated April 15, 16, 17, 22 and May 30, 2013. Record review and interview with the ED and DOC confirmed that these written notes and letter were not considered complaints at the time and were not documented as such. Interview with the DOC confirmed that these notes and letter should have been considered complaints. [s. 101. (2)]

2. The licensee failed to ensure that:
(a) the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response.

Record review revealed and interview with the ED confirmed that complaints are not reviewed or analyzed quarterly for trends. [s. 101. (3)]

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Issued on this 12th day of May, 2014

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