Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5

Original Public Report

Report Issue Date: June 23, 2023

Inspection Number: 2023-1525-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The Governing Council of the Salvation Army in Canada

Long Term Care Home and City: Isabel and Arthur Meighen Manor, Toronto

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.07.11 12:50:29 -04'00'

Additional Inspector(s)
Susan Semeredy (501)
Cindy Cao (000757)
Nrupal Patel (000755)
Elizabeth Cabral (000754)
Nital Sheth (500)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6-9, 12-15, 2023

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00016199/ CI #3031-000064-22 related to injury from a fall.
- Intake: #00019254/ CI #3031-000004-23, Intake: #00090233/ CI #3031-000034-23 related to improper care.
- Intake: #00019922/ CI #3031-000008-23, Intake: #00020963/ CI #3031-000013-23, Intake: #00021430/ CI #3031-000014-23 related to neglect.
- Intake: #00084163/ CI #3031-000021-23, Intake: #00087050/ CI #3031-000027-23 related to improper continence care.
- Intake: #00086525/ CI #3031-000024-23 related to improper oral care.
- Intake: #00087657/ CI #3031-000030-23 related to potential neglect and improper care.
- Intake: #00088311/ CI #3031-000032-23 related to resident's care.

The following intakes were completed in this complaint inspection:

- Intake: #00087738 related to potential neglect and improper care.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure resident #003 and #004 were assisted with care after eating as set out in the resident's plan of care.

Rationale and Summary
(i) Resident #003 required care to be provided with the assistance by Personal Support Workers (PSWs) after eating.

PSWs admitted that they did not provide the specified care to resident #003 after their meal. Registered Practical Nurse (RPN) acknowledged that the care was to be provided to resident #003 after eating as set out in their plan of care. The Director of Care (DOC) acknowledged that staff were to review and follow the care plan prior to providing resident care.

Failure to provide care assistance after eating put resident #003 at risk of further medical concerns.

Sources: Resident #003's care plan and progress notes. Interviews with PSWs and other staff. [000757]

(ii) Resident #004's care plan stated that the staff were to provide a certain type of care to the resident after their meal. During an observation, it was noted that the resident was not provided the care that

they needed after the meal. The PSW confirmed that they did not ask or assist the resident with the specified care. The DOC stated that the staff should have provided the care as specified in their care plan.

Failing to provide the resident with the required care put the resident at risk for skin breakdown.

Sources: Resident 004's clinical record review and interviews with PSW and DOC. [741150]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 3.

The licensee has failed to ensure that the effectiveness of resident #001's plan of care related to incontinence products was documented.

Rationale and Summary
The resident's care plan indicated they wore an incontinent product for a trial period of a few weeks. The care plan's documentation history indicated that this note was created several months prior. A progress note made by the DOC indicated that the home would try the specified incontinent product and review in a few weeks. Progress notes for a four-month period indicated that a review was not documented. The RPN indicated that it had been decided that the resident would continue with the specified product and the care plan should have been updated to reflect the change was no longer a trial. The DOC stated the effectiveness was reviewed but was unable to demonstrate it was documented within the resident's plan of care.

Sources: The resident's care plan, progress notes, and interviews with an RPN and other staff. [501]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a staff member used safe transferring techniques when assisting a resident.

Rationale and Summary

The substitute decision-maker for a resident shared evidence with the home that a PSW had forcefully taken a resident out of bed to provide them with an activity of daily living (ADL). The staff member had pulled on the resident while another staff member was outside in the hallway. Even though the resident resisted being transferred and appeared tired, the staff member continued. The other staff member joined them to complete the ADL.

The resident's care plan indicated they were to be provide the above ADL at a certain time if awake and were to be assisted with transferring by two staff. As well, the care plan stated not to grab and pull the resident while performing a transfer. The physiotherapist (PT) indicated that the staff did not follow the plan of care and transferred the resident in such a way that posed a risk of injury to the resident.

Failing to use safe transferring techniques put the resident at risk for injury.

Sources: CIR, the resident's care plan, evidence provided by the SDM, and interviews with the PT and other staff. [501]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that proper techniques to assist a resident with eating were followed.

Rationale and Summary
The resident's substitute decision maker (SDM) contacted the Registered Dietitian (RD) and shared evidence that showed a staff member assisting the resident to eat in a forceful manner. The resident was struggling to resist while the staff member continued. The RD acknowledged that the staff member had not used proper techniques to assist the resident and was retrained.

Failing to use proper techniques to feed the resident put them at risk for aspiration.

Sources: Evidence from the SDM, the resident's progress notes and an interview with the RD. [501]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure the home carried out every operational or policy directive that applies to the long-term care home.

Rationale and Summary
The Minister's Directive: COVID-19 response measures for long-term care homes indicates that homes are to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. This guidance document indicates homes must complete IPAC audits every two weeks unless in outbreak.

The home's COVID-19 Self-Assessment Audits between March to June 2023, indicated one missed audit in March 2023.

Failing to perform IPAC audits at least every two weeks put residents at risk for infectious disease, such as COVID-19.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, MLTC COVID-19 Guidance document for long- term care homes in Ontario, the home's self-assessment audits and an interview with the IPAC Lead. [000754]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that when a written or verbal complaint was made to the licensee or staff member, that the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the Patient Ombudsman under the Excellent Care of All Act, 2010 was provided.

Rationale and Summary
(i) The licensee submitted three CIRs related to complaints made by resident #001's SDM. The SDM stated that the home did not inform them of the above contact information. The DOC was unaware that this needed to be completed.

Sources: CIRs, and interviews with the SDM and DOC. [501]

(ii) The home received a compliant via e-mail related to the care and services for resident #004. The home's response did not include the Ministry's toll-free telephone number or contact information for the Patient Ombudsman.

The SDM for the resident and the Director Of Care (DOC) acknowledged that the response provided to the written complaint did not include the Ministry's toll-free telephone number or contact information for the Patient Ombudsman.

Sources: CIR, the home's internal investigations records, a response email sent to the complainant, an email reply by the SDM to the inspector and an interview with the DOC. [741150]

(iii) The home received a complaint via phone and e-mail related to the care for resident #006. The home's response did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the Patient Ombudsman.

The ADOC acknowledged that the response provided to the complaint did not include the required information.

Sources: The LTCH's internal investigation notes and interview with the ADOC. [000755]

WRITTEN NOTIFICATION: REPORTNG AND COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that when they were required to immediately forward the complaint to the Director, their response to the complainant confirmed that it was forwarded to the Director.

Rationale and Summary
(i) The home submitted three CIRs regarding complaints received from resident #001's SDM regarding the care of the resident. Within the responses submitted as part of the CIRs, there was no indication that the licensee was forwarding the complaints to the to the Ministry of Long-Term Care. The DOC admitted they were unaware that this needed to be completed.

Sources: CIRs, and interviews with the SDM and DOC. [501]

(ii) The home received a compliant via e-mail related to the care and services for resident #004.

The licensee's response e-mail to the complainant related to a resident's care did not specify if the licensee was required to immediately forward the complaint to the Director and did not confirm them that it was reported to the Director.

The Substitute Decision Maker (SDM) of the resident #004 and the DOC acknowledged that the home's response did not include information on the home's requirement to report it to the Director.

Sources: CIR, the home's internal investigations records, a response email sent to the complainant, email reply by the SDM to the inspector and an interview with the DOC. [741150]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

The licensee has failed to ensure that a report to the Director included name of the PSW who was present at the incident.

Rationale and Summary
The home submitted a CIR related to a complaint made by resident's SDM regarding improper/ incompetent treatment that resulted in harm or risk to the resident. The report indicated the DOC received evidence which described the resident being transferred in an unsafe manner by a PSW and an RPN. The CIR report listed the name of the RPN but did not include the name of the PSW. The DOC stated they did not see that option when making out the report or it could have been an oversight on their part.

Sources: CIR and an interview with the DOC. [501]