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
Telephone: (866) 311-8002

# Original Public Report

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| **Report Issue Date:** January 5, 2024 |
| **Inspection Number:** 2023-1525-0006 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **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** |
|---|---|
| Adelfa Robles (723) | Adelfa P Robles<br>Digitally signed by Adelfa P Robles<br>Date: 2024.01.05 16:48:39 -05'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 21, 22 and 28, 2023

The following intake(s) were inspected:

- Intake #00103177/CI: 3031-000083-23 was related to COVID-19 outbreak
- Intake #00103598 complaint related to resident to resident physical abuse and

Intake #00103253/CI: 3031-000084-23 were all related to the complaint

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

Infection Prevention and Control
Responsive Behaviours

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible;

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

A complaint was received by the home related to an incident when a resident threatened another resident causing the other resident to sustain injuries.

The resident's clinical records indicated that they had behaviours with specified triggers. The home's investigation notes indicated that a specified trigger could have caused the resident's behaviours resulting in the incident.

Staff who witnessed the incident identified a specified trigger that caused the resident's behaviours. Staff stated that there were no strategies developed prior to the incident when they experienced the previously identified triggers.

There was an increased risk of injury to the resident and others when there were no strategies developed related to resident's behaviours related to previously identified triggers.

SOURCES: A resident's clinical records and staff interviews.

[723]