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
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Original Public Report

Report Issue Date: November 6, 2024

Inspection Number: 2024-1525-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Governing Council of the Salvation Army in Canada

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 4, 7, 8, 9, 10, 11, 16, 17, 18, 2024

The following intake(s) were inspected in the Follow-Up (FU) inspection:
• Intake: #00119673 related to dining and snack services and;
• Intake: #00119672 related to infection prevention and control (IPAC).

The following intake was inspected in the Complaint inspection:
• Intake: #00122684 related to an allegation of neglect, skin and wound care and plan of care.

The following intake(s) were inspected in the Critical Incident (CI) inspection:
• Intake: #00119712 related to allegations of abuse;
• Intake: #00122666 related to an allegation of neglect and improper care;
• Intake: #00126646 related to a fall with injury and;
• Intake: #00126785 related to a disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1525-0002 related to O. Reg. 246/22, s. 102 (2) (b).
Order #001 from Inspection #2024-1525-0002 related to O. Reg. 246/22, s. 79 (1) 4.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessments of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

A Registered Practical Nurse (RPN) documented the administration of a treatment for the resident's altered skin integrity.

Two Personal Support Workers (PSWs) advised that the resident did not receive the treatment because it was no longer required. The resident's altered skin integrity resolved weeks prior, but did not communicate this to the nurse.

The RPN confirmed that the PSWs should have communicated that the treatment was no longer required so that it could be discontinued.

There was a risk to the resident when the assessments completed by different staff members were not consistent with and complemented each other.

Sources: Review of a resident's electronic medication administration record (EMAR), care plan history; and interviews with PSWs and RPN.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care when they were not promptly notified of the resident's altered skin integrity.

Rationale and Summary

Staff discovered that the resident had an area of altered skin integrity, and the SDM was not notified until the following day.

The Assistant Director of Care (ADOC) acknowledged that the SDM was not notified immediately.

Failure to notify the resident's SDM promptly may result in them not having the opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Review of a resident's progress notes, complaint received from SDM; and interviews with ADOC and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was

provided to a resident as specified in the plan related to skin and wound.

Rationale and Summary

The resident's plan of care indicated that they required assessments by the PSWs.

The resident had an area of altered skin integrity that went unnoticed until it had deterioated.

A PSW acknowledged that they did not assess the resident while providing personal care for two weeks while working with students and should have.

Failure of the PSW to follow the resident's plan of care and assess the resident may result in areas of altered skin integrity not being identified timely.

Sources: A resident's clinical records; and interview with a PSW.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The licensee has failed to ensure that a resident's altered skin integrity received immediate treatment and interventions to reduce, promote healing, and prevent infection.

Rationale and Summary

A PSW reported to a RPN that they observed an area of altered skin integrity on the resident. The RPN looked at the resident's altered skin integrity on the same shift but failed to take any action to address the area.

The RPN acknowledged being informed by the PSW of the resident's altered skin integrity's and should have completed an assessment of the site, notified the physician and initiated interventions and treatment when identified, and failed to do so.

When the resident's altered skin integrity was first identified, they did not receive immediate interventions and treatment to promote healing and prevent infection.

Sources: Review of a resident's clinical records and Skin and Wound Care Program Policy #11:02, revised June 28, 2024; and interviews with RPN and other staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

A) The home has failed to ensure that following the resolution of an outbreak, the outbreak management team (OMT) and the interdisciplinary IPAC team conducted a

debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak and a summary of findings created that made recommendations to the licensee for improvements to outbreak management practices, as required by Additional Requirement 4.3 under the IPAC Standard.

Rationale and Summary

The home was in a confirmed Respiratory Outbreak in two resident home areas. The IPAC Lead acknowledged that a debrief session with the home's OMT was not conducted and a summary of findings was not created following the resolution of the outbreak.

Failure to conduct a debrief session and summary of findings following the resolution of their respiratory outbreak may have affected the effectiveness of the home's outbreak management practices.

Sources: Review of Critical Incident report and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interview with the IPAC Lead.

B) The IPAC Lead failed to ensure that audits were performed regularly (at least quarterly) to ensure that all staff could perform the IPAC skills required of their role as required by Additional Requirement 7.3 (b) under the IPAC Standard.

Rationale and Summary

IPAC practice audits on personal protective equipment (PPE) and hand hygiene were not performed for dietary staff.
The Food Services Manager (FSM) and IPAC Lead both acknowledged that dietary staff were not audited to ensure that they could perform the IPAC skills required for their role.

Failure to audit all staff for their IPAC practices may affect the effectiveness of the home's management of their IPAC program.

Sources: Review of IPAC practice audits: Linens and Personal Care, Environmental Cleaning, Routine Practices, Food Services, Use of Gloves Audit, PPE and Hand Hygiene Tool (June, July to September 2024) and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interviews with IPAC Lead and FSM.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee has failed to ensure that on every shift, a resident's symptoms indicating the presence of infection were monitored.

Rationale and Summary

A resident displayed symptoms indicating the presence of an infection and was on additional precautions. Their symptoms of infection were not monitored for eight shifts.

The Infection Prevention and Control (IPAC) Lead acknowledged that the resident's symptoms of infection were not monitored every shift as required.

Failure of staff to monitor the resident's symptoms of infection every shift placed the

resident at risk of delayed treatment of their infection.

Sources: Review of a resident's clinical records; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed in the home.

Specifically, the use of PPE recommended by the CMOH when direct care was provided to a resident.

Rationale and Summary

A resident was was on additional precautions, and the home directed staff to wear a N95 respirator when direct care was provided to the resident. A PSW provided direct care to the resident without a N95 respirator, as per the CMOH recommendations.
Failure to wear the appropriate PPE when direct care was provided to the resident put other residents and staff at risk for infection.

Sources: Observation of resident care; review of a resident's clinical records and

Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Ministry of Health, April 2024; and interviews with PSW and IPAC Lead.