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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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: July 7, 2025

Inspection Number: 2025-1525-0004

Inspection Type:
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): June 16, 17, 18, 20, 24, 25, 26, 27, 2025 and July 2, 3, 4, 7, 2025
The inspection occurred offsite on the following date(s): June 23, 2025

The following Critical Incident Systems (CIS) intake(s) were inspected:

- Intake: #00137725 - Follow-up for Compliance Order (CO) related to infection prevention and control.
- Intakes: #00142524 – CIS # 3031-000009-25 and #00143168 – CIS #3031-000011-25 were related to Falls Prevention and Management
- Intakes: #00143726 – CIS #3031-000012-25; #00144231 – CIS #3031-000013-25; and #00146039 – CIS #3031-000020-25 were related to Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1525-0001 related to O. Reg. 246/22, s. 102 (8)

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

1) The licensee has failed to ensure that resident #003 was protected from sexual abuse.

Ontario Regulation 246/22, 2 (1) (b) defines sexual abuse as, any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitements d'ordre sexuel").

Resident #002 was observed having sexual behaviour towards resident #003. The Assistant Director of Care (ADOC) indicated that sexual abuse had occurred between residents #002 and #003 when a sexual behaviour was observed.

Sources: Home's investigation notes, residents #002 and #003's electronic health records; CIS report # 3031-000012-25; interviews with ADOC and resident #002.

2) The licensee has failed to ensure that resident #004 was protected from sexual abuse by resident #002.

Resident #002 was observed inside resident #004's room engaged in sexual behavior. The ADOC acknowledged that sexual abuse occurred when residents #002 and #004 were observed in sexual behavior.

Sources: The home's investigation notes, residents #002, #004's electronic health records; Critical Incident Systems (CIS) #3031-000012-25 and #3031-000013-25; interviews with ADOC and resident #002.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure safe transferring techniques were used when a resident, who required extensive assistance of two staff, was transferred

independently by a Personal Support Worker (PSW) and sustained minor injuries.

Sources: CIS #3031-000009-25; the home's investigation notes, resident electronic health records, interviews with resident, and the Director of Care (DOC)

WRITTEN NOTIFICATION: Police Notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure the appropriate police service was immediately notified of alleged sexual abuse of a resident by another resident. The ADOC indicated that they did not inform the police regarding this incident.

Sources: CIS #3031-000011-25 and interviews with the ADOC.