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

Public Report

Report Issue Date: November 3, 2025
Inspection Number: 2025-1525-0006
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 24, 27-31, 2025 and November 3, 2025

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00156164 [CI #3031-000032-25] related to disease outbreak

The following Follow-Up intake(s) were inspected:
-Intake: #00157341 was a Follow Up to Compliance Order (CO) related to resident plan of care

The following Complaint intake(s) were inspected
-Intake: #00159115 related to multiple care concerns

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1525-0005 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. 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 for All Act, 2010,

The home received a written complaint concerning the care of a resident. In responding to the complainant, the home did not provide contact information for the patient ombudsman.

Sources: Response email to complainant, interview with an Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A Pharmacist advised according to prevailing practices that a resident's medication administration record (MAR) must be signed immediately by the nurse who administered the medications to the resident.

A Registered Practical Nurse (RPN) and a Registered Nurse (RN) both acknowledged this was not the practice with a resident. The RN explained that the RPN would prepare the medications and the RN would administer them to the resident, then the RPN would sign the resident's MAR.

Sources: Resident's clinical records, policy Medication Administration, interviews with the RPN, RN, Director of Care (DOC) and Pharmacist.