Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 20, 2022	2022_940239_0004	012652-21, 017917-21, 001507-22	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd Toronto ON M4H 1P4

Long-Term Care Home/Foyer de soins de longue durée

Isabel and Arthur Meighen Manor
155 Millwood Road Toronto ON M4S 1J6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

WING-YEE SUN (708239), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 22, 23, 24, 25 and 28, 2022.

The following intakes were completed during during this Critical Incident System (CIS) Inspection:
Log #017917-21, CIS #3031-000014-21 related to neglect.
Logs #012652-21, CIS #3031-000008-21, and #001507-22, CIS #3031-000003-22 related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPNs), Administrative Manager, Scheduling Clerk, Personal Support Workers (PSWs), Housekeeping Aides, and residents.

During the course of the inspection the inspectors observed staff to resident interactions, conducted observations of the home, including resident home areas, reviewed residents' clinical records, staffing schedules, internal investigation notes, relevant home policies, and observed IPAC practices.

This inspection was completed concurrently with Complaint Inspection #2022_940239_0005.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided a beverage or a snack.

The home submitted a Critical Incident Systems (CIS) report to the Director advising that residents were not offered their evening beverage and snack.

A Personal Support Worker (PSW) and Director of Care (DOC) both acknowledged that residents were not offered their evening beverage and snack. The DOC advised that approximately 15 residents were affected.

Failing to provide residents with their evening beverage and snack put them at risk of decreased intake.

Sources: CIS report, and interviews with DOC and PSW. [s. 71. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner and ensure that each resident is offered a minimum of a snack in the afternoon and evening, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided assistance with hand hygiene prior to snack service.

A PSW served four residents an afternoon snack and beverage without assisting those residents with hand hygiene. These residents were observed eating and drinking independently.

The home's policy titled "Meal Service" directed staff to encourage or assist residents to wash their hands before and after meals.

The DOC acknowledged that staff should assist residents with hand hygiene before and after eating and drinking.

Failing to assist residents with hand hygiene increased the risk of transmission of infection.

Sources: Observation of afternoon snack pass, Meal Service Policy, and interview with DOC. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a resident's fall with hospitalization and significant change in health condition, within 10 days after becoming aware of the incident.

A resident had an unwitnessed fall and was transferred to hospital. The home received communication from the hospital that the resident had sustained an injury. The resident had a change in condition after their return from hospital. The Executive Director (ED) acknowledged that they were aware of the incident, but submitted the CIS report late.

There was no risk of harm to the resident, due to the late reporting of the incident to the Director.

Sources: CIS report, resident’s progress notes, and interview with ED. [s. 107. (4) 1.]

Issued on this 21st day of April, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.